SUMMARY AND RESPONSE TO PUBLIC COMMENTS
California Department of Insurance
CCR Title 10, Chapter 5, Subchapter 2
Article 11

Verbatim Text of Comments	Response
America's Health Ins. Plans(AHIP) Leanne Gassaway 07/20/09	**AHIP**
1. Proposed Regulations are Vague and Provide Insufficient Guidance for Consumers and Insurers In order to ensure access to affordable health insurance coverage and provide a simplified process for health care consumers, any regulations promulgated by the DOI regarding Postclaims underwriting and rescission processes should be predicated on a set of clearly identifiable, objective standards that provide a well-articulated process for application, medical underwriting, and rescission procedures. We are concerned that the proposed regulations fail to include objective standards and leave many important points open to interpretation. For example, the regulation repeatedly uses subjective terminology relative to health insurance applications that require health insurers to make subjective interpretations of responses to determine if the applicant "had doubts" or was "doubtful" of the information provided. In addition, we are concerned that the mandatory new response option of "NOT SURE" is vague, will confuse consumers, and result in the delay of the issuance of health insurance coverage. We believe that application questions should be clear and understandable and that health plans should identify any apparently inadequate, unclear, or otherwise questionable information on the application prior to issuing a policy. An accompanying obligation should be imposed on applicants to have knowledge of their medical information when applying for coverage. Before completing the application, consumers should review their medical history and should confer, as needed, with any treating physician or other health care provider to ensure that their information is accurate and complete. The incorporation of a "NOT SURE" response choice creates a disincentive for an applicant to have knowledge of their health history when they apply for coverage. We submit that the current approach taken in health history questionnaires that provide applicants with two response choices – "YES" or "NO" – with the opportunity to further explain the response brings a level of certainty and clarity to the application process. Health plans should then be charged with responsibility for obtaining the necessary clarification from the consumer regarding unclear or incomplete responses prior to issuing the policy.	**AHIP #1** The regulations balance the need for insurers to have flexibility in the application of their own underwriting guidelines and procedures against the regulator's need to set standards. Making factual determinations, such as whether an applicant has expressed doubt about a response to a health history question, is inherent in the nature of underwriting activities. Insurers must be able to interpret and apply their underwriting guidelines and to change them as claims experience and underwriting experience informs such changes. Insurers will always be required to make "subjective" determinations in the application and underwriting processes and this is based on the statutory requirements to complete medical underwriting and resolve all reasonable questions arising from or on the application. If an applicant's responses indicate doubt about the questions asked by the insurer, the insurer needs to follow up and that follow up is exactly what these regulations require. Similarly, if the applicant is truly Not Sure about what a question is asking or how to respond to it, the "Not Sure" response is the most truthful response for the applicant. If this response choice is not available, the applicant will have difficulty honestly answering the question; instead they would be guessing. It is also most helpful to the insurer who is responsible for completing underwriting of the application to know as early as possible which health history questions are potentially problematic for the applicant. The Department assumes that an applicant, as a layperson, is diligently attempting to answer every question on a health history questionnaire. The Department believes that when an applicant is truly unsure about the correct response, the applicant will not be confused by selecting the response choice "Not Sure". Disagree with the suggestion that Yes or No alone brings clarity and certainty. It creates uncertainty for the consumer whose most truthful response is Not Sure. Yes or No response options are limited and consumers don't understand that if they are truly Not Sure of a response, they are supposed to further explain their Yes or No response. The Department believes that offering the Not Sure response option should not delay the process since applications can also ask the

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	applicant to explain why they are "Not Sure. In fact the Department has recently approved an application submitted by Anthem Blue Cross, the largest individual health insurer in California that takes this approach. Provision of the Not Sure response choice should expedite underwriting since Not Sure responses will help the insurer quickly identify follow up areas by asking the applicant to identify areas where the applicant is unsure of either the question or their health history. Agree that health insurers are charged with responsibility for obtaining necessary clarification from the applicant and requiring the Not Sure response option will facilitate an insurer's completion of medical underwriting. There is nothing in the regulations that bars an insurer from requesting that an applicant complete the health history questions to the best of the applicant's ability
By failing to include a set of clear standards, the rule poses a threat to consumers by creating ambiguity in the application process and failing to provide a consistent set of requirements applicable to all health insurers. The DOI should seek to establish standards for post-claims underwriting that limit subjective interpretations, which create ambiguity and would cause unnecessary delays and confusion for California consumers.	The Department has clearly identified the types of underwriting activities and the sources of health history information that are accessible to insurers as part of the standards for avoiding postclaims underwriting. Underwriting an applicant's health history is heavily fact-driven and will always require the underwriter's professional judgment. This doesn't make the process "subjective" but the process does necessarily require judgment calls as the underwriter gathers information, considers the applicant's self-reported information and consistently applies the insurer's detailed and often complicated medical underwriting guidelines.
2. Proposed Regulations Fail to Provide an Adequate Timeframe for Implementation AHIP believes that the proposal in its current form does not provide adequate time for carriers to comply with the regulations and to educate agents and employees about the new requirements. We note that the proposed rules will require the development of new application forms, the filing of such applications for approval with the DOI, and the distribution of the new applications with appropriate training of field staff. In addition, the new requirements will require significant overhauls of internal procedures which will require adequate time to ensure the proper implementation and training for the new processes.	**AHIP #2** Disagree. Insurers have been on notice for several years that regulators have been requiring more rigorous and thorough pre-issuance underwriting. This awareness of change in industry standards has come about through enforcement actions, public hearings and private and city attorney lawsuits The Department filed three major rescission enforcement actions in 2008 and settlement agreements required improvement to underwriting processes reflecting the substance of these regulations These Settlements also required revised health history applications reflecting the substance of these regulations. (Settlement Agreements with Health Net Life and Health Ins. Co, Anthem Blue Cross and Blue Shield Life are all available on CDI's

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To avoid threatening the availability of coverage options for consumers in the individual market during the regulatory review and compliance implementation process, we recommend that the effective date be modified to reflect a minimum of 180 days from the date of approval by the Office of Administrative Law. This additional time could prove critical for DOI staff to review and approve all applications for hundreds of companies, as well as for health insurers to make the necessary changes to the application forms, underwriting processes, rescission procedures, construct relationships with vendors who have claims information and/or personal health records, and to appropriately educate agents and employees about these changes.	website). These three companies cover over 85% of the individual health insurance market in CA. These three companies are already engaged in Corrective Actions that not only reflect activities and standards in these regulations but go beyond the requirements of these regulations. CDI regularly receives and reviews health insurance applications and conducts the required statutory review. The standards set in these regulations merely implement existing state law and the CDI cannot and does not presume that insurers are currently out of compliance. As noted, the largest insurers have already agreed to these standards and more through settlement of CDI and DMHC enforcement actions and are proceeding with implementation via Corrective Action Plans. The remaining individual health insurers in California have been on constructive notice of the pending regulations for over a year. Disagree for the need for delayed implementation of the regulations since the State's largest insurers have been in the process of revising both the health history questionnaires and underwriting processes for the last two years since the Department's rescission enforcement actions were filed and subsequently settled. There is no reason to believe that new regulations that require more robust underwriting, which most companies have already implemented, will threaten coverage. In fact, the individual health insurance market continues to be active and constantly introducing new health insurance coverage choices. Industry standards are to engage in ongoing agent education about new statutory requirements such as the imposition of the attestation requirement last January 2009.
3. Benefits of Proposed Regulation Are Outweighed by Unintended Consequences California consumers seeking health insurance coverage should be provided with quality, affordable, and portable coverage in a timely manner. We are concerned that the adoption of these rules will limit the ability of insurers to issue coverage by creating a time-consuming, subjective, mandatory underwriting process. AHIP believes that by failing to provide a set of clear standards for applications, underwriting, and rescissions, the regulatory proposal being considered will provide only minimal benefits to consumers seeking health coverage in California and will result	**AHIP #3** As noted, the three largest individual health insurers have already agreed to meet underwriting standards as reflected in these regulations via Settlement Agreement. There has been no evidence that these standards have limited coverage issuance whatsoever. The Department asserts that the regulations set clear standards for applications, underwriting and rescissions and that implementation of these standards will benefit both consumers and insurers by clarifying requirements and

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in significant unintended consequences. The minimal benefits are further limited by the delays in the issuance of coverage that will result from the confusion and accompanying costs associated with implementing these new requirements. Specifically, section 2274.74 mandates that insurers *must* include in their underwriting process a procedure to verify the applicant's health status through the review of at least four data sources. These data sources include: 1. the applicant's personal health record, if available, and health history information from external services; 2. commercially available medical and pharmaceutical claims information; 3. self-reported information from the application; and 4. the applicant's medical records or the insurer's own claims history (if applicable). AHIP members are concerned with the requirement around verification of information in the application – which includes an attestation of its accuracy – with data sources that are unverifiable and subject to unchecked amendments. For example, personal health records (PHR) can be modified at any time by a consumer and they do not include an attestation or other statement regarding the accuracy of the information contained therein. Information in a PHR is completely controlled by the individual and may be inaccurate or incomplete. Furthermore, access to PHR systems is strictly limited by the patient and would require additional authorization and processes to access an applicant's PHR in coordination with the PHR provider (e.g., Google Health or Microsoft). In addition, we note that the vast majority of consumers provide accurate and complete information when they apply for health insurance coverage such that additional follow-up is not required. Moreover, rescissions are a rare occurrence and any proposed changes to the underwriting and rescission process should be targeted with surgical precision to address specific concerns rather than adopting an overly broad approach. As such, we do not support the extensive and unnecessary requirements that would result in all California consumers bearing the burden of the higher costs associated with this regulation. **4. Proposed Regulations Should Only Apply to the Individual Market**	leveling the playing field. Disagree that benefits will be minimal; there is no evidence to support this assertion. In fact more clearly written health history questions will reduce confusion and reduce underwriting costs. Disagree. The proposed regulations, including the original text, do NOT mandate the use of four different sources of health history information. The amended text clarifies that at least one source of objective health history information other than the self-reported information on the application must be consulted and only if available. It is industry standard currently to consult at least one, if not more, sources of health history information other than the application. The driver of variance in the underwriting time of an application is the complexity of the individual's application as well as the particular insurer's practices and this time is not expected to increase by much as insurers expand their use of software and data mining of claims data. The benefits of these regulations, once fully implemented by insurers, will be a dramatic decrease in rescissions and reduction in the very significant costs of conducting a postclaims rescission investigation and actually executing a rescission. Insurer's costs should be reduced on a net basis. See changes in proposed text made to the definition of a PHR in Section 2274.72(d) and use of a PHR in Section 2274.73(a). PHRs that are consumer-based are not allowed to be used under these regulations. Under these regulations, insurers are continued to be expected to use their own professional judgment regarding what additional health history information to seek under the standard set in Section 2274.74 (a) which is "to the degree necessary to assure that it has obtained the health history information in the detail needed for complete and consistent application of its medical underwriting guidelines and rating plan." Insurers are given sufficient flexibility in applying this standard to undertake underwriting activities in accordance with both the law and their medical underwriting guidelines as requested by the commenter. **AHIP #4**

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Finally, we request that the scope of the regulation be further clarified to focus on the concerns with coverage rescissions and application forms in the individual health insurance market. We note that the application of this underwriting framework to large group is unnecessary because they are not underwritten on an individual basis. It is similarly unnecessary to apply the new requirements to small group because of the guarantee issue requirements that currently exist for this market. We therefore offer the following amendment to Section 2274.71 for consideration: (a) This article shall apply to all health insurance policies as defined in Insurance Code section 106(b) and all certificates issued under policies in the individual market ~~. where the insurer applies medical underwriting guidelines and where guaranteed issue requirements do not apply.~~	Disagree. The scope of these regulations is properly limited to any health insurance policies where the insurer chooses, at its option, to apply its medical underwriting guidelines and rating plans. Should an insurer choose NOT to underwrite certain small group policies or large group, in those instances, these standards would not apply unless the insurer reserves the right to rescind based on health history or health status. No change is necessary because these standards are only applicable to health insurance policies where the insurer applies medical underwriting guidelines and reserves the right to rescind policies based on health history or health status; this can occur in both the individual and group markets. The current text of the regulations correctly acknowledges that small group policies where guaranteed issue rules apply are exempted from these regulations.
Anthem Blue Cross (ABC) Natalie Cardenas 07/20/09	**ABC**
I THE PROPOSED REGULATIONS VIOLATE THE CALIFORNIA ADMINISTRATIVE PROCEDURES ACT **A. The Department Has Not Established "Necessity" Regarding the Scope of the Proposed Regulations** A state agency must establish that a regulation is necessary within the meaning of the APA. The term "necessity" is defined at Government Code § 11349(a) as: "Necessity" means the record of the rulemaking proceeding demonstrates by substantial evidence the need for a regulation to effectuate the purpose of the statute, court decision, or other provision of law that the regulation implements, interprets, or makes specific, taking into account the totality of the record. For purposes of this standard, evidence includes, but is not limited to, facts, studies, and expert opinion. The Office of Administrative Law ("OAL") has further defined a state agency's obligation to satisfy the necessity requirement in 1 California Code of Regulations § 10(b)(2) by , requiring the record of the rulemaking proceeding to include: … information explaining why ***each provision*** of the adopted regulation is required to carry out	THESE GENERAL COMMENTS TO DO NOT ADDRESS SPECIFIC PROPOSED TEXT. PLEASE SEE UPDATE IN FINAL STATEMENT OF REASONS.

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the described purpose of the provision. Such information shall include, but is not limited to, ***facts, studies, or expert opinion.*** When the explanation is based upon policies, conclusions, speculation, or conjecture, the rulemaking record must include, in addition, supporting facts, studies, expert opinion, or other information. An "expert" within the meaning of this section is a person who possesses special skill or knowledge by reason of study or experience which is relevant to the regulation in question." [emphasis added]	THESE GENERAL COMMENTS DO NOT ADDRESS SPECIFIC PROPOSED TEXT. SEE FSOR.
In the Initial Statement of Reason ("ISOR"), the Commissioner states, "Over the past three years, consumers have made the Commissioner aware of their increasing concerns about postclaims underwriting and rescission." (ISOR, page 1) The Commissioner further states the consumers complained of the questions utilized by insurers were "overbroad, misleading and confusing." (*Id*.) As a result of these consumer complaints, the Commissioner concludes, "that insurance consumers need greater protection from unlawful rescissions and, accordingly, proposes these regulations." (ISOR, page 2)	
By the proposed regulation, the Commissioner is not seeking to merely address the issue of rescissions, but is seeking to regulate the entire underwriting process. However, the Commissioner provides no substantial evidence establishing the necessity for the overreaching scope of the regulation. A comprehensive survey by America's Health Insurance Plans in 2007 of over one million policies in force during 2005 and 2006 concluded that the rescission rate was 0.23% of policies in 2005 and 0.15% in 2006.1 Additionally, as the largest insurance carrier in California, as a percentage of new policy sales in 2008, rescissions occurred in less than one-tenth of one percent of the policies.	Disagree. The Commissioner has conducted several market conduct examinations since 2006 of insurer's rescission and pre-issuance underwriting practices.Since 2006, the Commissioner has examined Anthem Blue Cross Life and Health Insurance Company, Blue Shield Life and Health Insurance Company (two times), Health Net Life and Health Insurance Company, PacifiCare Life and Health Insurance Company and Aetna Life and Health Insurance Company. During these examinations prohibited postclaims underwriting was uncovered. Enforcement actions followed some of these exams which were settled. In these Settlement Agreements (see CDI website) insurers agreed to adopt corrective actions, many of which are reflected in these regulations. Additional market conduct examinations which are continuing revealed ongoing problems with prohibited postclaims underwriting further justifying the necessity of these regulations.
As the numbers illustrate, less than 0.3% of applicants who are accepted for coverage are subject to rescission. Nonetheless, the Commissioner is imposing requirements on the underwriting process that requires all insurers to pull medical records for all applications and search commercial data bases for information pertaining to the applicant. (See e.g., Proposed Regulation § 2274.74(a)(1), (2), (3)) Imposing these requirements on the 99.7% of applicants that are never rescinded is contrary to the Commissioner's stated purpose of providing "greater protection from unlawful rescissions." Moreover, the ISOR contains no evidence, let alone, substantial evidence	The Commissioner is not subjecting underwriting standards to avoid postclaims underwriting on applications/ insurance policies where the insurer undertakes never

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regarding why imposing these requirements on applications not subject to the rescission process is necessary. To the contrary, the Commissioner acknowledges that following the requirements of the proposed regulations will not result in the discovery of any meaningful information in certain cases. Specifically, the Commissioner states, "For example,in the case of a healthy young person, there may simply not be any prior claims or pharmaceutical data available and the insurer may need to rely solely on the application submitted by the individual." (ISOR, page 9) Even with this acknowledgement, the proposed regulations would require an insurer to undertake a meaningless investigation.	to rescind, cancel or limit the policy. See change in Amended Text of the Regulations in Section 2274.74 (c). Disagree. The proposed regulations do NOT require insurers to pull medical records for all applications nor do they require searching commercial databases for all applications. See changes to proposed text in Section 2274.74(a) which clearly establish that at least one source of health history information other than the applicant's self-reported information must be obtained and then, only if such information is available. This is widespread industry standard practice today and as such does not impose a burden on insurers. This approach not only reflects a prudent business approach but balances consumer protection with insurer's desire to pursue efficient and cost effective underwriting practices.
The excessive breadth of these regulations is further demonstrated by their application to group policies that are medically underwritten. (Proposed Regulation section 2274.71) The Commissioner does not provide any evidence establishing the necessity for including such group policies. As written, it is unclear if an insurer would have to pull the records for every individual to be covered under a group policy. If so, this would require thousands of individuals' medical information to be requested and yet there is no evidence that there is any necessity for imposing such a requirement.	Disagree. The scope of these regulations is correctly limited to any health insurance policies where the insurer chooses, at its option, to apply its medical underwriting guidelines and rating plans. Should an insurer choose NOT to underwrite certain small group policies or large group, in those instances, these standards would not apply unless the insurer reserves the right to rescind based on health history or health status. No change is necessary because these standards are only applicable to health insurance policies where the insurer applies medical underwriting guidelines and reserves the right to rescind policies based on health history or health status; this can occur in both the individual and group markets.
The costs associated with a requirement to seek medical records for all applicants would be substantial. Anthem receives about 1,200 individual applications per day. If the average application required three medical records to be pulled, Anthem would be requesting about 1 million medical records per year. At an approximate cost of $50 to pull a medical record—for the insurer alone—the added annual administrative cost just for Anthem would be $50 million. At the provider level, there would be additional burdens and cost.	THESE GENERAL COMMENTS DO NOT ADDRESS SPECIFIC PROPOSED TEXT. SEE FSOR.

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The negative impact on consumers would also be significant, and not only because these higher costs would be passed on to consumers. With many applicants immediately passing medical underwriting, Anthem is able to get many applicants into coverage immediately, which we have found to be a significant component of consumer demand for coverage. With carriers being required to pull medical records on all applicants, consumers will be frustrated by wait times, and many will not follow-through with purchasing coverage, significantly increasing the number of uninsured.	The regulations do not require Anthem to pull medical records for every application. See changes to Amended Text of Regulations at Section 2274.74 (a)
According to a survey conducted by America's Health Insurance Plans of almost 2 million individual market applications, only 18.5 percent do not make it through the medical underwriting process (e.g., withdrawn by the applicant)2. This number would increase substantially with the delays required by these proposed regulations, resulting in more uninsured.	Disagree. Insurers have a vested interest in performing careful and prudent pre-issuance underwriting to avoid the need for a costly and legally risky post-issuance rescission investigation. The proposed regulations do not impose burdensome or costly underwriting requirements given the statute's mandate to conduct necessary pre-issuance medical underwriting.
B. The Commissioner Has Not Established The Requisite Authority For The Scope of The Proposed Regulations Under the rules of statutory construction, every word of a statute must be given its usual, ordinary import, according significance to every word, phrase and sentence. (*Esberg v. Union Oil Company* (2002) 28 Cal.4th 262, 268 [121 Cal.Rptr.2d 203].) Applying this accepted rule, the Legislature was clear is limiting the scope of this statute to rescissions and cancellations resulting from a defect or error in the underwriting process. The proposed regulations ignore the limited scope of the statute and seek to regulate the entire underwriting process – even in cases not involving postclaims underwriting. The limited scope of the statute to Postclaims underwriting is evident based on the plain text of the statute which specifically prohibits rescissions under the limited circumstance when there is an issue of not completing underwriting and resolving questions on an application. In other words, if there is no rescission, there is no issue of "complete medical underwriting" under Insurance Code § 10384.	The Commissioner has established the requisite authority. See changes to proposed text in Section 2274.74 (c) which clarifies that the standards in Section 2274.74 (a)and (b) do not apply in the event that an insurer never undertakes to rescind, cancel or limit a health insurance policy. Agree with the commenter that " IF there is no rescission, there is no issue of complete medical underwriting". The changes in the proposed text clearly reflect this interpretation of Section 10384.
	Agree that if there's no rescission, there's no issue of " complete medical underwriting" and the Amended Text of the Regulation Section 2274.74 (c)reflects exactly that position.
The other provisions cited as authority and reference do not provide any basis for regulating the entire underwriting process as provided by the proposed regulations. *Thompson v. Occidental Life Insurance Company of California* (1973) 9 Cal.3d 904; 109 Cal.Rptr 473 cited by the	The intent standard established by *Thompson v. Occidental Life Insurance Company of California* (1973) 9 Cal 3d 904 has been superceded in its entirety by the recent enactment of federal law. See FSOR discussion of the impact of federal health care

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Commissioner as reference for these regulations specifically addressed the rescission process but did not impose any requirements on the underwriting process as a condition to rescind an insurance policy. By these proposed regulations, the Commissioner is exceeding the scope of statute by dictating specific underwriting requirements to be applied to all applications – not just cases involving postclaims underwriting. Moreover, the proposed regulations exceed the scope of *Thompson* and Insurance Code § 10384 by prohibiting rescissions when there is no issue of the completion of underwriting**.** As a consequence, the proposed regulations would be invalid if adopted. (*Esberg v. Union Oil Company* (2002) 28 Cal.4th 262, 269-270 [121 Cal.Rptr.2d 203, 208]; *Green v. Ralee Engineering Co*. (1998) 19 Cal.4th 66, 82 [78 Cal.Rptr.2d 16] *quoting California Assn. of Psychology Providers v. Rank* (1990) 51 Cal.3d 1, 11 [270 Cal.Rptr. 796]; *Woods v. Superior Court* (1981) 28 Cal.3d 668, 680 [170 Cal.Rptr. 484]; *see* Government Code, §§ 11342.1, 11342.2.)	reform, specifically Section 2712 Prohibition on Rescissions. As a result of the recent enactment of federal health care reform law, the Thompson case has been deleted from the Reference. See comment above regarding changes to Section 2274.74(c) which limits duty to adhere to underwriting standards when an insurer undertakes to never rescind, cancel or limit a health insurance policy.
The proposed regulations exceed the Commissioner's statutory authority by imposing requirements that render Insurance Code § 10380 meaningless. As stated above, the prohibition of postclaims underwriting is limited to the limited circumstances when the rescission is due to issues involving the completion of underwriting. Insurance Code § 10384 has no prohibition on rescission, canceling or limiting coverage in cases involving fraud. These types of circumstances are addressed in Insurance Code § 10380, which specifically allows an insurer to limit or bar the right to recovery if a false statement is made in an application with the intent to deceive or if the statement materially affected the risk assumed by the insurer. Under the proposed regulations, the Commissioner is imposing an absolute bar on such actions under section 2774.74(c). This is an impressible expansion of Insurance Code § 10380 and prohibited by the APA.	See above response to this comment re: the applicability of the regulations when an insurer undertakes to never rescind, cancel or limit a health insurance policy. Disagree with commenter's statement that CIC Section 10384 does not apply to cases involving fraud. See discussion of recent *Nieto* case in the FSOR where the appellate court agreed with the trial court's application of Section 10384 EVEN though the trial court had properly made a finding of fraud. The insurer's burden of proof in instances where an insurer seeks to rescind coverage based on an applicant's alleged making of a false statement or committing fraud in the application process has been superseded by federal law, specifically Section 2712 of the recently enacted federal health care reform. See detailed discussion in FSOR. To the extent Insurance Code Section 10380 governed the insurer's burden of proof with regard to an applicant's making of a false statement in the application process, it has been superseded by federal law.
D. Section 2274.73 Violates The APA Requirements of Clarity, Authority and Reference	Disagree. Section 10291.5 provides broad authority to the Commissioner to establish specific requirements for health history questions to assure that the application is clear and concise and to assure that the questions are reasonable for medical

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Section 2274.73 sets forth several standards relating to applications. The Commissioner's limited authority with respect to applications is set forth in Insurance Code § 10291.5(c), which prohibits the Commissioner from approving an application unless the application contains clear and concise questions designed to ascertain the health condition or history of an applicant which is reasonable and necessary for medical underwriting purposes.	underwriting purposes. Insurers rely heavily on the self-reported information provided by the applicant thus making standards governing the health history questions even more critically important both for consumer protection and for industry use of the applicant's responses.
Through subsection (a) of the proposed regulation, the Commissioner is imposing specific requirements on what information must be requested by an insurer in the underwriting process. Personal Health Records ("PHR") must be requested (whenever possible) and such information is required to be relied on instead of the application – if sufficient. Insurance Code § 10291.5(c) does not contain any specific requirement to use any one source of information over another or the preference that one source of information should be given with respect to another. In addition to exceeding the scope of the statute, the Commissioner has not established the necessity for such a requirement because there is no substantial evidence to support such a requirement. The necessity for such a requirement is contradicted by the ISOR which states PHRs are not widely used (ISOR, page 5) but the proposed regulation nonetheless requires their use. Such a requirement lacks clarity since an insurer has no objective manner to determine when such information is available.	Agree in part. See amended text Section 2274.74 (a) which clarifies that an insurer is free to choose from any source of health history information other than self-reported health information and only if available. This clarification addresses this comment. This section of the text has also been amended to make use of a PHR optional. See amended text of Section 2274.74(a). The use of PHRs is not required by the regulations; it is suggested as one alternative source of objective non self-reported health history information. The text has been amended in Section 2274.74(a) to clarify that PHRS are to be requested only if available and may be used in addition to self-reported health history information. This comment is surprising coming from Anthem Blue Cross since Anthem was reported as have PHR operational " for all members" in a Report specially prepared by the Department of Insurance published in May 2008 entitled : Personal Health Records: A Helpful Tool for A Healthier You. (See PHR report page 8 at: http://www.insurance.ca.gov/0500-about-us/upload/PHRreport051908.pdf) In fact, most all of the major California health insurers have reported to CDI that their PHRs are operational for all members. Thus, the reports are available to members; it's unclear how much members are using them.
Subsection (d) requires questions to be clear, specific, unambiguous and written to be understood by a layperson. The ISOR acknowledges that applicants have an obligation to provide accurate and correct health history information. (ISOR, page 8) In subsection (d)(4), the Commissioner requires an application to contain a provision to allow an applicant to respond to a health history question by answering unsure, don't know, etc. Insurance Code § 10291.5(c) does not contain any such requirement. Moreover, this requirement completely undermines the applicant's obligation to provide accurate information. Subsection (d)(5) also imposes another requirement not set forth in the statute that requires an insurer to investigate such responses through interviews, etc. Such requirements exceed the scope of the statute. The Commissioner also fails to establish the necessity for such requirements because there is no evidence to support such a requirement. It should also be noted the purported issues being addressed by these requirements could be addressed through the policies and procedures employed by an insurer during the rescission investigation process. It does not appear the Commissioner evaluated any	The purpose of requiring the response choice of "Not Sure" in addition to Yes or No is precisely to permit the applicant a full opportunity to answer accurately and truthfully. The Department agrees that applicants have an obligation to complete their insurance application to the best of their ability and to give complete responses. By requiring the Not Sure response option, the applicant will better be able to meet

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such proposals as required by the APA.	this obligation and the insurer will gain additional insight into the health history areas where further underwriting might be warranted. The Department has had recent experience with the Not Sure response option and learned that insurers can in fact use this option to more efficiently underwrite an application. The statute requires questions to be clear and unambiguous. Response options are part of the question. In order to make the question clear and unambiguous, a Not Sure response option must be provided. If the applicant truly cannot answer Yes or No and the truthful answer is Not Sure, the applicant is unable to accurately respond unless the Not Sure response option is available. The commenter's suggestion that the issues addressed by these requirements be addressed by an insurer's internal policies and procedures is impractical and would provide no guaranteed consumer protections. Such an approach would result in terrific inconsistency from one insurer to another. The Commissioner did evaluate different approaches to these requirements, including making the Not Sure response optional, and rejected such approaches as ineffective and resulting in inconsistency for prospective insureds. The commenter suggests the status quo be considered as an alternative. This alternative was considered and rejected as insufficient to address the problems associated with rescission including unclear and confusing health history questions, inability of insureds to participate in post-issuance rescission investigations, to name but a few of the problems that exist and that these regulations are intended to address.
Additionally, proposed subsection (e)(2) prohibits health history questions from having an unlimited look-back period. As insurers do have questions that contain unlimited look-back periods for serious conditions that reflect actuarial risk for the entire lifetime, such a requirement would require insurers to change their underwriting guidelines. Because the Department does not have the authority to mandate specific underwriting guidelines, we request that this requirement be eliminated.	Disagree. Subsection (e)(2) does not prohibit health history questions from having an unlimited look back period. It allows such time periods for health history questions if supported by sound actuarial principles. See actual wording of this subsection. Disagree. The Department has the authority granted in CIC 10291.5 to set standards for health history questions on an application that is part of the insurance policy form.

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E. The Proposed Underwriting Standards In 2274.74 Violate The APA Requirements Of Authority, Reference And Clarity

The underwriting standards proposed in section 2274.74 contain a variety of subjective requirements that enlarge the scope of the statute and violate the clarity requirements. For example:

• § 2274.74 (a) (1) and (3) would require insurers to obtain the applicants' PHR, "if available". This requirement exceeds the scope of the statute because there is absolutely no statutory requirement to obtain any type of specific information or obtain information from a specific source. It is unclear how to comply with such a requirement since PHR are not readily used and there is no objective manner to determine if they are available within the meaning of the regulation since the standard is subjective. Also, this open-ended requirement lacks clarity because an insurer would never know if it fully complied with the requirement because of the open-ended nature and undefined requirement of how many sources an insurer would have to use. For example, is one source enough or would every source be required?

• § 2274.74 (a)(2) would require insurers to obtain and evaluate commercially-available medical information about an applicant. Again, this requirement exceeds the scope of the statute because there is absolutely no statutory requirement to obtain any type of specific information or obtain information from a specific source. Also, this is an open-ended requirement that lacks clarity, and an insurer would not know if it was fully compliant with the requirement unless it checked every single commercially available source in the entire marketplace. The term "commercially available" is also problematic because it does not provide any clear definition as to when a source becomes commercially available and if cost is a factor in determining commercially available.

• § 2274.74 (a)(3) and (4) would require insurers to check "reasonably available sources" of health history information. Again, this is an open-ended requirement that exceeds the scope of the statute and lacks clarity.

Response

Agree in part. Several amendments have been made to the text that are responsive to these comments.

Section 2274.74 (a) has been amended to clarify that the insurer's use of the objective information contained in a PHR is in addition to the self-reported health history on the application. Further the regulations have been amended to clarify the definition of a PHR is limited to objectively derived health history information.

Section 2274.74(c) has been amended to clarify that at least one source of non self-reported health history information should be obtained and used by an insurer during underwriting, but only if such information is available. The commenter asks if one source is enough or would every source be required. The amendments clarify that one source would be enough, subject to the requirements of the insurer's own underwriting guidelines and the general duty to resolve all reasonable questions arising from or on the application. See above discussion of optional use of PHR. The regulation requires the insurer to ask if the applicant has a PHR and if so, to provide it. As noted earlier, most insurers have PHRs available to members.

Section 2274.(a)(2) has been amended to clarify that if an insurer chooses to access a commercially available pharmaceutical database in lieu of a commercially available medical claims database, the standard would be satisfied.
The term " commercially available" has its plain meaning. There are many commercially available sources of health history information routinely used by insurers today for underwriting purposes.

Disagree. This requirement is not open-ended. See changes in text made to Section 2274.74 (a) clarifying the limit on how much an insurer must obtain health history information. The standard enunciated in this subsection provides needed flexibility to insurers to utilize and follow their own underwriting guidelines balanced against the statute's mandate to "complete medical underwriting and resolve all reasonable

Verbatim Text of Comments	Response
• § 2274.74 (b) (2), (3), and (4) would require insurers to compare all of the collected health history information and review for information that appears "doubtful or otherwise questionable." There is no objective manner to determine compliance with this requirement. Again, this requirement exceeds the scope of the statute because there is absolutely no statutory requirement or basis to impose this requirement.	questions." Disagree. The statute clearly mandates that if there any questions arising from or on the application, which would necessarily include information obtained by the insurer during the underwriting of the application, they must be resolved. The specific regulatory requirement that insurers identify and resolve any information that appears to be inconsistent, ambiguous, doubtful and the like flows precisely from the statutory requirement.
• § 2247.74 (b) (6) requires insurers to "resolve all reasonable questions or omissions", which "may include, but is not limited to, information obtained through (a) the insurer's further communication with the applicant, (b) a review of medical records and other sources of health history or health status information, such as PHR, for each individual who has applied for insurance coverage, or (c) a commercial pharmaceutical or medical information database." As with the other provisions, this requirement exceeds the scope of the statute because there is absolutely no statutory requirement or basis for this requirement or any requirement to use specific information from a specific source. This requirement is open-ended and lacks clarity.	See response immediately above. This requirement is not open-ended as it is limited by the constraint that it must be done "to the degree necessary…" as stated in the amended text of Section 2274.74(a).
• § 2274(c) absolutely prohibits rescinding, canceling or limiting a policy or increasing a rate any time after receiving a claim unless an insurer complies with each step in subsections a and b. As set forth above in the discussion regarding the scope of the proposed regulations, this prohibition significantly expands the scope of the statutes and cases cited in the reference section. More importantly, this section places an insurer in a position where it will be required to decline more policies or accept applications and being unable to resort to rescission even in cases of out right fraud (i.e., defacto guaranteed issue). Also, rate increases for trend and experience have nothing to do with the initial underwriting process and to tie the two issues together in this manner is a significant and impermissible expansion of the underlying statutes and cases that these proposed regulations are purporting to implement.	Disagree. The statutory mandate is to "complete medical underwriting"; these regulations specify and implement the statutory mandate. Disagree. Nothing in these regulations prohibits an insurer from rescinding in cases of out right fraud as long as the insurer has not violated the prohibition of postclaims underwriting. See discussion of *Nieto* case for a recent example of where the trial court's finding of fraud was upheld as was the court's application of the postclaims underwriting statute, CIC 10384. Disagree that the regulations will require insurers to decline more policies. The insurers have been expected to follow the statutory mandate to avoid prohibited postclaims underwriting in the absence of regulations. The regulations are silent and do not address routine rate increases based on trend. They refer to increasing the rate charged for an individual or group) based on postclaims underwriting activities

Verbatim Text of Comments	Response
	only. This section does not prohibit annual rate increases that result from increases in trend.
F. Section 2274.74 Lacks "Consistency," In Accordance With The APA	
The APA, at Government Code § 11349.1(a), states that the OAL shall review all regulations adopted and submitted to it for publication, and make determinations regarding certain specified standards. One such standard is "consistency," which is defined at California Government Code § 11349(d) as "being in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or *other provisions of law* [emphasis added]."	This general comment does not address the proposed text.
Proposed Section 2274.74 would put into place requirements to determine whether an applicant has or has not had medical conditions in order to complete medical underwriting, and proposed Section 2274.73 requires and that application question must meet a "reasonable layperson standard". However, despite this reasonable layperson standard, proposed Section 2274.73 also requires insurers to allow the applicant to indicate whether he or she is unsure of the answer to the question. This requirement is inconsistent with the proposed requirements to determine whether the applicant does or does not have a medical condition.	The commenter misreads the "reasonable layperson standard" requirement. The regulation requires insurers to assume the applicant is responding to the health history questions as a layperson as this is true 99.99% of the time. The regulation does not impose the reasonable layperson standard on the question itself; only the interpretation by the insurer of the response. The requirement to offer a Not Sure response option to questions is unrelated to the reasonable layperson standard. See previous responses explaining the purpose of the Not Sure response option; namely to provide the applicant the opportunity to be absolutely truthful if they are truly not sure of how to respond.
G. Section 2274.76 Violates The APA's Authority, Consistency And Clarity Requirements	
Subdivision (e) prohibits an insurer from issuing a policy unless it has received an attestation required by Insurance Code § 10119.3 "unless the insurer is processing the application without the involvement of an agent." The phrase "involvement of any agent" is not defined and lacks clarity since it potentially broader than the definition of assistance contained in subsection (c). Moreover, the requirement to obtain the attestation as a condition of issuing a policy expands the scope of Insurance Code § 10119.3, which is intended to protect applicants subject to a rescission. As stated above, the scope of this requirement would need to be limited to cases involving rescissions.	Disagree. The phrase "involvement of any agent" is taken out of context. The regulation clearly states that insurers are not required to obtain the written attestation of any agent only if no agent has been " involved" in completing or submitting an application for health insurance. This is a very bright line and is entirely consistent with the statutory mandate. The phrase " involvement of an agent" has its plain meaning and refers to applications that are submitted directly to the company by an applicant without going through an agent. Disagree. The commenter misreads the statute. There is nothing in the statute CIC 10119.3 that limits its application to cases involving rescission. The duty of the

Verbatim Text of Comments	Response
	agent to attest and the insurer to obtain the attestation is independent of whether or not there is a subsequent rescission. In addition, the intent of this statute is to protect the insurers who need to rely on the veracity of the information provided by agents to prospective insureds. A major purpose of this statutes is to protect insurers from unscrupulous agents who misrepresent the insurer to applicants and may alter information on an applicant's application thus undermining the insurer's ability to properly underwrite.
The attestation requirement of Insurance Code § 10119.3 is limited to assistance with applications. Once the application is submitted, subsection (g) is proposing the requirement to provide an attestation if there are discussion between an agent and an applicant. However, this contradicts and the requirements of Insurance Code § 10019.3 since the application has already been submitted making it unclear what the agent is attesting to. Also, this requirement contradicts subsection (e) because an insurer would not know if an agent and applicant have any discussions after an application is submitted. An insurer would therefore always be at risk of violating subsection (e).	Disagree. The statute addresses an agent's assistance with an application. There is nothing in the statute that prohibits ongoing assistance by an agent once the application is submitted and this does occur. It is precisely because assistance can be ongoing, including after the application has been submitted, that the regulations address further attestations if such assistance occurs. The regulations impose a continuing duty on an agent, not the insurer, to notify the insurer if there have been any discussions after an application is submitted. The ongoing attestation requirement is necessary since underwriting is ongoing up to the point of decision on the application.
H. Section 2274.77 Violates The APA Requirements Of Authority And Consistency Subsection (b) requires an insurer to request the applicant to review the policy and returned application and advise an insurer if the response to a health history question does not reflect a correct or complete answer based on the applicant's knowledge of the facts sought or appreciation of the question because no such requirement exists in statute. Moreover, this instruction is essentially requesting the applicant to review and re-answer the questions. In such a case, how would an insurer ever know when it could rely on an applicant's response to a health history question?	Disagree. This regulation does not prohibit the insurer from relying on the applicant's application responses. It protects the insurer by requiring the applicant to review the application received and underwritten by the insurer. This step protects the insurer- and the applicants- against fraud by agents, which has been detected by the Department. This type of fraud occurs when an agent receives a handwritten application from an applicant and proceeds to submit the applicant's information electronically and alters it in order to avoid declination of the application. CDI has detected agents who have engaged in such fraud where rescissions have been carried out shortly thereafter by the insurer.
I. Section 2274.78 Lacks "Consistency," In Accordance With the Administrative Procedure Act;	

Verbatim Text of Comments	Response
The APA, at Government Code § 11349.1(a), states that the OAL shall review all regulations adopted and submitted to it for publication, and make determinations regarding certain specified 10 standards. One such standard is "consistency," which is defined at California Government Code § 11349(d) as "being in harmony with, and not in conflict with or contradictory to, existing statutes, court decisions, or *other provisions of law* [emphasis added]."	This general comment does not address any proposed text.
Proposed subsection 2274.78 (i) would require insurers to allow rescinded subscribers to appeal to the Department without first exhausting the insurer's internal appeals process. This requirement is inconsistent with current law that requires subscribers to first appeal insurer decisions with the insurer's internal appeals process. Thus, Anthem requests that the Department only apply any third-party review of rescission disputes after the subscriber has exhausted the insurer's internal appeals process.	Disagree. The commenter is mistaken. There is no current law that requires an insured to utilize an insurer's internal appeal process prior to seeking assistance from the Department of Insurance. As it stands today, any insured may seek Department assistance at any time over any insurance-related issue without having to appeal first to their insurance company. The Commissioner does not have authority to alter statutes requiring the Department to receive and investigate consumer or provider complaints.
Subsection (c) imposes on the insurer the requirement to determine that an applicant's misrepresentation or omission must be of facts known to the applicant and the insurer must ascertain that the applicant appreciated the significance of the information requested on the application. *Thompson* merely stated a rescission would not be appropriate if the applicant had no knowledge of the facts sought or failed to realize the importance of the information related to him. *Thompson* at 916. The regulation exceeds the scope of the case by seeking to impose a standard relating to the application.	See FSOR discussion of the impact of federal health care reform law regarding intent standard for rescission that must be proved in order to legally rescind coverage. Federal law now imposes a standard on the insurer seeking to rescind insurance coverage. It does not conflict with the postclaims underwriting requirements but the Thompson standard has been replaced by federal law.
Subdivision (f) imposes a diligence standard on an insurer to complete an investigation. The requirement is written on the assumption the insurer can obtain information from 3rd parties, without cooperation from the applicant. However, there may be circumstances where an investigation cannot occur without an authorization or some other cooperation from the applicant. In such cases, there is no clarity how the insurer could comply with this regulatory requirement and it is unclear if this lack of cooperation would constitute good cause within the meaning of subsection (g).	The regulation provides for the circumstance where an insurer cannot complete the rescission investigation within 90 days or less. The regulation creates a duty for the insurer to diligently pursue completion of an investigation. Since insurers are required to continue to pay claims since the policy remains in force, it is in the best interests of insurers to timely complete a rescission investigation. The regulation requires a showing by the insurer of its diligence; it does not require strict adherence to the 90 completion requirement if the insurer can show good cause for the longer timeframe. If the insured fails to provide authorization or other cooperation if an investigation is undertaken by an insurer, this would likely be considered a breach of

Verbatim Text of Comments	Response
	contract in that this is a typical insurance policy requirement. The "good cause" requirement is intended to protect the insurer during an examination. If the insurer can show good cause for lengthier than allowed time for completion of the investigation, the insurer will be compliant with these regulations.
II. DEFINITION FOR COMPLETING MEDICAL UNDERWRITING MUST BE COMPLETELY OBJECTIVE	
Individual market contract rescission in California is one of the most active areas of litigation in the U.S, with costs associated with litigation likely exceeding $100 million over the last few years. With case law finally beginning to settle relatively small levels of ambiguity in existing law, any new requirements that are anything short of being completely objective will result in new uncertainty and new rounds of litigation that will add substantial costs to the system and discourage consumers and insurers from participating in the market.	This comment does not address the text.
Proposed Section 2274 proposes a myriad of subjective standards for an insurer to complete medical underwriting (see examples from proposed Section 2274.74 listed above). Such a level of subjectivity would encourage litigation for every rescission on the basis of whether an insurer completed medical underwriting consistent with the new proposed section. Anthem strongly requests that the definition of completing medical underwriting be rewritten to create a completely objective standard. We propose the following construct that would make it 100% clear in every case whether an insurer has or has not "completed medical underwriting". A health insurer may not rescind an individual market policy unless it has completed medical underwriting. For the purposes of this section, a health insurer has completed medical underwriting if it has done all of the following: a. Solicited health history information with health history questions approved by the Department b. Evaluated the application responses for completeness	Disagree. The standards set in Section 2274 74 are as objective as is possible given the industry need to have sufficient flexibility to follow their own medical underwriting guidelines, adopt new technology that will become available with improved HIT and utilize the professional judgment of its underwriters. . Underwriting each application is a highly fact-driven activity and by definition involves professional judgment by underwriters as they review the gathered health history information and apply the company's underwriting guidelines. Disagree. The proposed language appears to reflect the same general propositions as the proposed text with much less specificity, detail and clarity and would not likely pass legal muster. The requirements proposed by the commenter are no more " objective" than the detailed activities listed in Section 2274.74.

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c. Compared this information with any data about the applicant in its own claims/pharmacy databases d. Investigated any inconsistencies e. Attached a copy of the application with a letter to the subscriber instructing him/her to contact the insurer immediately if there are any inaccuracies and that an inaccuracy may result in rescission.	
These requirements are very objective, and all parties would be clear on whether the insurer did or did not complete medical underwriting. Any subjective requirements will result in substantial market disruption.	This comment does not address the proposed text.
III. INSURERS CANNOT BE REQUIRED TO PULL MEDICAL RECORDS ON EVERY APPLICANT	The regulations do not require insurers to pull medical records on every applicant.
Proposed Section 2274 proposes a myriad of subjective standards for an insurer to complete medical underwriting (see examples from proposed Section 2274.74 listed above). Among these requirements is a requirement to pull all "reasonably available" health history information, including medical records. Even language such as "if appropriate" will likely lead insurers to collect medical records in all cases in order to comply with the regulations with abundant caution due to high levels of litigation.	Section 2274.74(a) has been amended to clarify that the requirement to obtain health history information about an applicant is constrained by several factors: 1) at least one objective source must be sought, if available and 2) the various types of underwriting activities contained in the regulations must be pursued only " to the degree necessary to assure that it has obtained the health history information in the detail needed.." for completion of underwriting. This does NOT translate into a blanket requirement to obtain medical records in every single case.
While we agree that medical records are typically available, pulling medical records for every applicant would create new delays and barriers to coverage that do not exist today for the over 99% of applicants who we believe from our experience provide accurate and complete information.	See above response.
For example, a large portion of the 1,200 applications we receive per day for coverage contain responses that indicate no major medical problems. For these applications, we can issue coverage immediately, which both satisfies a large element of consumer demand and gets applicants into coverage as quickly as possible.	There is no requirement in these regulations to seek medical records for all applicants. These regulations require insurers to access at least one outside source of information other than the self-reported health history information precisely because there have been problems reported by insurers relying solely on self-reported

Verbatim Text of Comments	Response
The cost burdens associated with a requirement to seek medical records for all applicants would be substantial. Anthem alone receives about 1,200 individual market applications per day. If the average application required three medical records to be pulled, Anthem would be requesting about 1 million medical records per year. At a cost of $50 to pull a medical record—for the insurer alone—the added administrative cost just for Anthem would be $50 million. At the provider level, there would be additional burdens and cost.	information.
	See above.
The negative impact on consumers would also be significant, and not only because these higher costs will be passed on to consumers. With many applicants immediately passing medical underwriting, Anthem is able to get many applicants into coverage immediately, which we have found to be a significant component of consumer demand for coverage. With carriers being required to pull medical records on all applicants, consumers will be frustrated by wait times, and many will not follow-through with purchasing coverage, increasing the number of uninsured significantly.	When insurers are more diligent in accessing outside objective sources of health history information as required by these regulations, underwriting an application will be faster and more efficient.
According a survey conducted by America's Health Insurance Plans of almost 2 million individual market applications, only 18.5 percent do not make it through the medical underwriting process (e.g., withdrawn by the applicant)3. This number would increase substantially with the delays required by these proposed regulations, resulting in more uninsured.	Disagree.
For all these reasons, we strongly request that the Department not include the collection of medical records in the definition of completing medical underwriting.	Many insurers have testified to the value of medical records under certain specific circumstances as part of the medical underwriting process. It would be unclear and not specific to ignore this potentially valuable source of health history information as part of the underwriting activities available to insurers.
IV. EVALUATION OF AN ELECTRONIC PERSONAL HEALTH RECORD AS PART OF THE UNDERWRITING PROCESS IS NOT POSSIBLE	This comment does not address specific proposed text. Disagree. The regulations foresee much greater use of PHRs in the future.
While we agree with the Department that the health care system would benefit from interoperable health records that could be evaluated for a number of purposes, including any medical underwriting, the industry is several years away from such a verifiable health record becoming widely available. Existing personal health records and electronic health records are not in a format that can be viewed by insurers as part of their underwriting process. Thus, any requirement by the	The text has been amended in Section 2274.73 (a) to clarify that use of PHRs shall be requested and used only if available. Clearly, if an applicant does not have a PHR or chooses not to provide their PHR, the insurer is not required to use this source of health history information for underwriting.

Verbatim Text of Comments	Response
Department to try to evaluate a personal or electronic health record will result in significant delays and barriers to coverage.	The commenter confuses and conflates interoperable health records (used by doctors) with personal health records (used by consumers). The regulation clearly does NOT address electronic health records (also called electronic medical records).
V. INSURERS CANNOT BE REQUIRED TO CHECK THIRD-PARTY CLAIMS AND/OR PHARMACEUTICAL CLAIMS DATABASES WITHOUT STATUTORY CLARIFICATION ON ELECTRONIC SIGNATURES	
Anthem agrees with the Department that checking at least one commercially-available claims or pharmacy database should be part of the underwriting process. However, recent legal concerns regarding the California law and the use electronic signatures to authorize the collection of this information have slowed down this enhancement for the majority of applications that are submitted electronically. Thus, without a change in state law that clarifies that electronic signatures can be used to authorize the collection of claim information from a third-party, a requirement by the Department to collect this information will create delays and a potential barrier to coverage.	The Department appreciates Anthem's agreement with the proposed text in Section 2274.74(a) that requires checking at least one commercially-available claims or pharmacy database as part of required complete medical underwriting. The Department has no opinion on the topic of current law governing use of electronic signatures except to point out that the regulations as proposed envision electronic communications and records as an integral part of the underwriting and enrollment process in Section 2274.75(a)(6) which references the Civil Code Section governing electronic records. Since Anthem and other insurers are heavy users of electronically submitted health insurance applications, which utilize an electronic signature feature, the Department assumes that this barrier, should it exist, can be overcome for similar uses such as authorization of collection of claim information from a third party. Note that these regulations do not require the use of electronic signatures to authorize the collection of claim information from a third- party. Insurers who are concerned about the state of the law as it applies to this particular use of electronic signatures can obtain written signatures from applicants via fax or scanned documents should a barrier to electronic signatures in this context exist.
VI. REQUIRED TIMEFRAMES MUST REFLECT POTENTIAL DELAYS IN DATA COLLECTION FROM THIRD-PARTIES AND NEED TO RESOLVE DISPUTES QUICKLY	
Throughout the proposed regulations, the Department is establishing timeframes that try to balance a need for quickly resolving disputes while providing enough time to make thorough decisions. We have the following comments on specific timeframes proposed:	

Verbatim Text of Comments	Response
• Proposed subsection 2274.78 (g) would require insurers to complete an investigation within 90 days of initiating the investigation. While this is a reasonable timeframe, there must be a mechanism for insurers to "stop the clock" if the insurer is having difficulty receiving information from a third-party, such as a medical record. Without accommodation for delays, individuals will be able to game the system, as there is no requirement for third-parties to respond in a timely manner. The ability to game the system will affect the market in a similar way as guaranteed issue without an individual mandate, where individuals can wait to get coverage until services are needed—resulting in higher costs and reduced coverage. Thus, we request a mechanism for insurers to "stop the clock" if a third-party is not providing requested information on a timely basis.	Section 2274.78(g) clearly provides the opportunity for the insurer to "stop the clock" on the timeframe for completion of the rescission investigation if good cause for the delay can be shown. Good cause will vary from case to case and must be evaluated by the Department's examiners on a case by case basis. There is nothing in these regulations that relates to an individual mandate used an analogy by the commenter.
• Proposed subsection 2274.78 (g) also requires insurers to send a written notice of the status of its investigation to the insured every 30 days. This requirement does not fit well with Anthem's practice and the practices of others in the industry that have established a single-point-of-contact that are in regular communication with the subscriber being investigated. Thus, we request that the insurer communicate with the subscriber at least every 30 days regardless of the method of communication.	The written notice of status requirement is a significant part of the existing Fair Claims Settlement Practices regulations (CCR 2695.1 et seq.) which all insurers are currently required to follow. This requirement to send written notice of the status of the investigation exactly mirrors current claims investigation requirements which Anthem presumably follows. If Anthem chooses to use a single point of contact approach, this approach does not preclude the assigned Anthem contact person from generating a written status letter every 30 days thus complying with the notice requirement.
VII. THE DEPARTMENT SHOULD CONTRACT WITH AN INDEPENDENT ENTITY TO RESOLVE RESCISSION DISPUTES Subsection 2278.78 (i) proposes that a rescinded subscriber have the ability to appeal the decision to the Department. In addition to our request above that the external appeal take place after the subscriber exhausts the insurer's internal appeal process, we also believe that the Department should contract with an independent third-party to conduct any third-party review of rescission disputes. When policymakers established independent medical review (IMR) for medical-necessity disputes, the process was specifically established with the ability to appeal to an independent	The Department lacks statutory authority to contract with an independent third-party review to conduct any reviews of rescission disputes and therefore cannot adopt this suggestion. .

Verbatim Text of Comments	Response
review organization. We believe this works well in part because the independent organization is independent from the political process, where parties are subject to political forces and policymakers can be placed in politically precarious positions. Thus, we request that the Department outline a process by which—similar to IMR—the Department contracts with an independent review organization for the purpose of resolving rescission disputes.	The Department notes that express statutory authority exists for the referenced Independent Medical Review process noted by the commenter but does not exist for the process requested by the commenter.
Assoc. of Ca. Life & Health Ins. Co. (ACLHIC) Anne Eowan 07/20/09 **Section 2274.70 Purpose** (a) The regulation exceeds the Department's existing regulatory authority by intermingling provisions of the code that relate only to rescission with other sections of the code that relate only to underwriting, and in some instances apply to neither. For example, Section 10113 does not apply to underwriting or rescission and is a provision applicable only to the policy. Section 10119.3 imposes a requirement on the acceptance of an application and is not tied to a rescission process. The regulations should separate out what is required under general underwriting, and what is required should a company, rescind a policy. (c) This subsection interprets law as requiring an application to be part of a policy form. An application precedes the policy and is a separate form filed with the Department. The Department states in the "Initial Statement of Reasons" that the "health questionnaire is part of both the individual health insurance application and the health insurance policy itself." Yet, ACLHIC can find no statutory basis for this interpretation, and none is given in the regulations. The Department is applying 10291.5 to the application as if it was part of the policy, and thus would exceed its authority. Also in subsection (c), the Department applies 10291.5(b)(1) to the history questionnaire; however, the Legislature set forth a separate and distinct section and standards for applications in 10291.5(c) and (d). The statute requires application questions to be unambiguous and clear. This provision, by bootstrapping (b) (1), applies a different standard established by the Legislature and	**ACLHIC** **ACLHIC §2274.70** Disagree. CDI has interpreted, made specific and clarified sections of the Insurance Code that are inextricably related. An application for health insurance is received and underwritten and, if approved, a policy is issued. Section 10113 governs the policy as a contract and if that policy is pursued for rescission, provisions of the Insurance Code, such as Section 10113 are involved. Similarly, Ca. Ins. Code §10119.3 requiring an agent's attestation regarding application information is inextricably linked with a rescission if pursued and the insurer relies on information supplied on an application where the agent assisted. (c) Disagree. Insurers have insisted on making the health insurance application part of the policy itself and the application includes insurance contract provisions binding on both parties in addition to the health history questions. Indeed insurers have submitted health insurance applications including their health history questionnaires to CDI for approval under CIC§ 10291.5 for quite a while. CIC §10291.5 provides express statutory authority for CDI's review and approval of a health history questionnaire on a health insurance application. Disagree. These Insurance Code provisions are linked and are applicable to both the questions asked and the policy form itself and state the statutory standards for review.

Verbatim Text of Comments	Response
would exceed the Department's authority. (d) The regulation exceeds the Department's existing regulatory authority by seeking to impose requirements on supplemental questionnaires and scripts used in the initial underwriting process. Section 10291.5 (c) applies to the application of the health insurer and does not even reference supplemental documents or scripts. Apart from the obvious administrative burdens imposed by this subdivision, complying with it would be impractical and in many cases impossible. Supplemental questionnaires and scripts are used in telephone conversations and are broad, general guidelines. This is because telephone conversations cannot follow scripted guidelines exactly as each conversation involves human interaction and conversation related to unique conditions. Thus, each conversation is unique. **Section 2274.71 Scope** (a)The article would apply to all group and individual health insurance policies for which medical underwriting occurs, except for guaranteed issued policies. The exceptions would therefore only be for conversion, HIPAA, and small group policies. Thus, the bill goes far beyond the individual market, and would apply all the same extensive medical underwriting rules to the group market, including the attaching of an enrollment form to each group certificate, even if rescission is not done in the group market. Further, because the regulations tie otherwise separate underwriting and rescission processes together, it appears as though insurers would have to do the extensive reviews of medical records, personal health records, etc. for group certificate holders as required under Section 2274.74 when they are essentially guaranteed coverage and cannot be excluded under a group policy. The Department has stated on numerous occasions that these regulations are trying to address what they believe are problems in the individual market. The regulations should take that into consideration and limit the application to the individual market without imposing burdensome and unnecessary regulation which would adversely impact the issuance of coverage in the group market. In addition, the proposed regulations should not apply to other forms of coverage, including	(d) Disagree. With respect to supplemental questionnaires and scripts used by insurers as part of their underwriting process, CDI has authority to approve these vehicles if the insurer wishes to bind the applicant to statements made per CIC §10381.5. Based on this expectation, CDI views such supplemental questionnaires and scripts as adjuncts to the health insurance application. Insurers have reported recording structured interviews used for underwriting the applications, most likely so they can later rely on them during a rescission action if necessary. **Section 2274.71 Scope** The scope of these regulations is properly limited to any health insurance policies where the insurer chooses, at its option, to apply its medical underwriting guidelines and rating plans. Should an insurer choose NOT to underwrite certain small group policies or large group, in those instances, these standards would not apply. To provide for uniform application of the prohibition of postclaims underwriting, CDI cannot arbitrarily exclude some health insurance policies that are underwritten. Any health insurance policy that falls within the definition of health insurance found in CIC 106(b) that is also an underwritten policy should be subject to the proposed regulation. CDI has no statutory basis for arbitrarily selecting which underwritten policies should be exempted from the postclaims underwriting prohibitions. If a policy category is NOT subject to medical underwriting, it is already excluded by Subsection 2274.71(a). NOTE: The amended text of Section 2274.74(c) clarifies that the standards to avoid postclaims underwriting standards do not apply to policies where the insurer never undertakes to rescind, limit or cancel. If an insurer undertakes to never rescind group policies, for example, the underwriting standards set in Section 2274.74(a) and (b) would not apply to group policies.

Verbatim Text of Comments	Response
supplemental forms of health insurance and specialized health insurance. Presumably, dental and vision only policies would not be included in the scope of the regulations, since no medical underwriting occurs but there is no specified exemption. Other forms of specialized insurance, such as chiropractic only coverage would also be included. Making these forms of coverage subject to the extensive underwriting requirements is unnecessary and burdensome.	The commenter is mistaken in viewing underwriting and rescission as separate. CIC 10384 directly ties completion of medical underwriting, for example, to whether rescission is allowed. If rescission is not practiced in the group market, as this commenter suggests, the regulations do not apply. See Section 2274.74 (c). Any policy, such as dental or vision only or supplemental health insurance, that is NOT underwritten, is automatically excluded from the scope of these regulations. CDI does not have statutory authority to specifically exempt any other underwritten policies that fall within the CIC definition of health insurance.
Within the individual market, non-comprehensive policies should be exempted since rescission is also not an issue. Those would include supplemental forms of health insurance, such as reimbursement-based accident only, specified disease, Medicare supplement insurance, federal employee coverage (such as TRI-CARE) and short term limited duration insurance. In the short-term health insurance market, coverage is typically issued the day after application for individuals who need coverage immediately for only very short periods of time (30 – 180 days). Imposing underwriting standards which will take weeks or even months to complete will restrict this important consumer option from the market and will undermine its value as "gap" coverage for those between employer sponsored coverages.	See above comment.
We also would recommend that policies which the insurer indicates are non-rescindable be exempt from the regulations, since there are no repercussions for the applicant should complete medical underwriting not occur.	Agree. Non-rescindable policies are excluded from the scope of these regulations. See Section 2274.74 (c) of the Amended Text.
(b) In these regulations, the Department is setting forth an extensive regulatory scheme that is supposed to make it clear what an insurer's duties are with regard to underwriting and rescission; yet, this provision specifically states that these regulations cannot be relied upon by insurers, and further establishes that the Department has the right to impose other undisclosed and unnamed requirements on insurers. This provision renders these regulations ambiguous and subjective. Clarity of these regulations can only be achieved by striking this entire section and inserting a safe harbor for an insurer that follows the regulations. Without a safe harbor the regulation fails to achieve its stated purpose of defining the standards that insurers are required to meet.	(b) There is no statute authorizing or requiring the Department to create the "safe harbor" requested by this commenter. These regulations benefit insurers by establishing much greater specificity and clarity as to the requirements for pre-issuance underwriting, questions on the health history application, investigations and execution of rescissions and agent attestation. CDI estimates the cost to insurers of complying with these regulations noted that insurers who have already reached rescission settlements with the Department including Blue Shield Life and Health Insurance Company, Health Net Life and Health Insurance Company and Anthem Blue Cross Life and Health Insurance Company have completed their investment in more robust underwriting processes as outlined in these regulations. These regulations clarify and make specific the general term "postclaims underwriting" thereby enhancing certainty facing insurers whose rescissions are subject to

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2274.72 Definitions (a) "Policy" includes group certificates and fraternal benefit societies. As mentioned previously, the regulations should be limited in scope to the individual market, and exclude supplemental, short term limited duration and specialized health insurance policies.	Department examination. **Section 2274.72** CDI lacks statutory authority to arbitrarily discriminate among medically underwritten policies. Since all are subject to CIC 10384, all must necessarily be included within these regulations.
(b) Imposes a "reasonable layperson standard" where it is ultimately unnecessary to do so. Not only would the imposition of a new and ill-defined legal standard add an additional layer of complexity and confusion to these regulations, but the Department has already developed language in these regulations that would clearly and cleanly articulate the Department's expectation that an application's health history questionnaire must be "clear, reasonable, unambiguous, and written to be understood by … " (2274.73 (d)(1)), "… the average individual who lacks professional training and experience in medicine (2274.72(b)). Instead of creating an entirely new legal standard, that with it would bring a whole host of questions and concerns, the Department can make a stronger and clearer statement about their expectations by simply removing the "reasonable layperson standard" definition (2274.72(b), and modifying the two sections that reference the standard as follows: Proposed Regulation: 2274.73(a) Inquiries into an applicant's health history shall hold applicants to the reasonable layperson standard …	Disagree. The "reasonable layperson standard" is not a new legal standard. It is already used by insurers in their adjudication of emergency services claims as required by federal law. Insurers must apply a reasonable layperson standard in determining whether an insured as reasonable in using emergency room in a particular situation. It is a highly appropriate standard to be used in the context of an insurer posing clinically based health history questions to a non-clinical applicant. The proposed substitute language adopts the regulation's standards for how health history questions are to be constructed and subsequently evaluated by CDI attorneys charged with approving such forms. It fails in that it doesn't set a clear standard for the insurers to use when they evaluate an applicant's responses.
ACLHIC Proposed Substitute Language: *2274.73(a) Inquiries into an applicant's health history shall be clear, reasonable, unambiguous, and understandable to a person who does not have any professional training and experience in medicine.* Proposed Regulation: 2274.73(d) Questions on an application for health insurance coverage shall: (1) Be clear, specific, unambiguous and written to be understood by a reasonable layperson.	See above comment.

Verbatim Text of Comments	Response
ACLHIC Proposed Substitute Language: *2274.73(d) Questions on an application for health insurance coverage shall:* *(1) Be clear, specific, unambiguous and written to be understood by a person who does not have any professional training and experience in medicine.*	
(c) Personal health record (PHR). While PHRs may be on the cutting edge of technology, it is not clear why a PHR should carry more weight than the application itself. A PHR can currently be maintained by an internet server, such as Yahoo, not just health insurers. Further, a PHR can be maintained/added to/and modified by the applicant. While an application must be signed and attested to by the applicant as being true, a PHR can be modified and there is no attestation as to accuracy or completeness. Thus, to place as much weight as this regulation does on a PHRs veracity and reliability is to thwart the underwriting process. At the very least, if insurers are required to use PHRs, they should be able to apply equal weight to an application. Alternatively, use of PHRs should be optional.	Each of the commenter's concerns about PHRs have been addressed. See amended text in Section 2274.72(d) and Section 2274.73(a).
(e) Material information. What is the difference between "material" and medical information that is reasonable and necessary for underwriting, as required under 2274.73 (c)? Further, it is not clear what "specific" information is meant to be included? Either it is material or not, although all information ought to be considered material if insurers are to complete full medical underwriting.	Insurers use more than "medical" information as part of their underwriting; such as age. Age is most definitely material but it is not medical information. Prior insurance coverage may be material information to underwriting but it is not medical information as that term is commonly understood. Whether information is material or not depends on the insurer's medical underwriting guidelines and rating plan. Where the term "medical underwriting" appears in the regulations, it carries with it the stated definition regardless of whether it's capitalized or not. The definition describes both the process and purpose of medical underwriting and provides the necessary foundational meaning for the regulations.
(e) Medical Underwriting. Where this term is used in the regulations, it is not capitalized, so it is unclear whether it refers to the definition. At places, the use of the word seems to conflict with the definition.	
Section 2274.73 Standards for Health History Questions on an Application for Health Insurance Coverage (a) Again, "reasonable layperson standard" should be amended as described in our comments under Section 2274.72 (b).	**Section 2274.73** Disagree. See above comment.
	If an applicant refuses to provide his/her own PHR, obviously the underwriter

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A PHR cannot be relied upon, since an applicant can refuse to give access to a PHR or retroactively amend a PHR after seeing the questions on an application, and a PHR is not attested to by the applicant.	cannot use that information. PHRs that have consumer- generated information are excluded by definition from these regulations. See changes to Section 2274.72 (d).
(c) How does this requirement fit with sub (e) of the same section? Isn't medical underwriting already defined in 2274.72 (f)? What is an "essential" standard? That term goes beyond what is required under Section 10291.5 (c)(2).	Disagree. CIC 10291.5 (c)(2) states that questions shall only gather information that is necessary. Essential is comparable to necessary and does not exceed the statutory standard. Insurers have voluminous medical underwriting guidelines all of which are intended to be used to determine prospective risk.
(d) (1) This subsection states that questions must be written so that they will be understood by a reasonable layperson. This is not a "standard", as appropriate. ACLHIC would suggest substituting the language as proposed under Section 2274.72 (b).	See comment above re: reasonable layperson standard.
(2) It appears that underwriting standards will be part of the review of the application. Is that the intention? How will the Department conduct those reviews who will conduct them? Further, the regulations should specifically state that a specified time period may be the life of the applicant, since sound underwriting principles would have to be the standard.	Requiring that the time periods for health history questions be related to the insurer's underwriting standards comports with the "necessary" requirement of CIC 10291.5 (c) (2) and does not mean that CDI is going to review medical underwriting standards. However, under the examination authority, the Commissioner could examine an insurer's medical underwriting standards in relationship to the appropriateness of health history questions under CIC 10291.5(c) (2).
(3) The word "recent" prior to "consultations" should be stricken. It assumes that only recent consultations are relevant to underwriting.	The use of the word "recent" is constrained by the overriding rule that insurers are allowed under Section 2274.73(b) to ask questions that are reasonable and necessary for medical underwriting.
(4) Subdivisions (4) and (5) should be collapsed so that insurers can have flexibility in developing their questions...such as "don't know" or "unsure" and provide an opportunity for the applicant to explain. It is not clear in (4) that this is authorized. There should be an explicit authorization that an insurer may decline coverage if the application is incomplete, without having to go through extensive underwriting.	(4) The purpose of requiring the response choice of "Not Sure" in addition to Yes or No is precisely to permit the applicant a full opportunity to answer accurately and truthfully. The Department agrees that applicants have an obligation to complete their insurance application to the best of their ability and to give complete responses. By requiring the Not Sure response option, the applicant will better be able to meet this obligation and the insurer will gain additional insight into the health history areas where further underwriting might be warranted. The Department has had recent experience with the Not Sure response option and learned that insurers can in fact use this option to more efficiently underwrite an application.

SUMMARY AND RESPONSE TO PUBLIC COMMENTS
California Department of Insurance
CCR Title 10, Chapter 5, Subchapter 2
Article 11

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(e) Again, the drafting of questions that might be "likely to mislead" applies California Insurance Code (CIC) Section 10291.5(b) to a health questionnaire. The Legislature enacted a separate provision in the code, Section 10291.5(c) for the review of applications. Thus, the subsection should either be stricken for lack of authority or made consistent with the statute.	The statute requires questions to be clear and unambiguous. Response options are part of the question. In order to make the question clear and unambiguous, a Not Sure response option must be provided. If the applicant truly cannot answer Yes or No and the truthful answer is Not Sure, the applicant is unable to accurately respond unless the Not Sure response option is available. Insurers do not need CDI's approval to decline coverage if the application is incomplete. Disagree. CIC 10291.5(b) standards apply to any questions in a health insurance policy. Since insurers insist on the health insurance application being an integral part of the policy, the statutory standard prohibiting a policy provision that is "likely to mislead" applies.
(1) A prohibition against the use of compound questions will require an extremely lengthy application to be filled out. ACLHIC members estimate that the application could be as long as 100 pages. Washington went this course and their application is 35 pages. However, other states such as Utah have allowed carriers to group body systems together under one question, and then allow applicants to explain any answers below. This keeps applicants from having to answer repetitive questions about body disorders one at a time. A similar approach should be used in California.	(1) CDI has already approved a health insurance application for Anthem Blue Cross that meets the requirements of these regulations and it is not extremely lengthy. The proposed regulations governing questions on a health insurance application allow for a variety of approaches to be taken in organizing the questions.
(3) - (6) An insurer cannot know the mind of the applicant, and therefore whether an applicant would or could "understand the significance" of a physical system, or "guess and speculate" about such. The requirement that insurers develop questions that could somehow protect against this is subjective and lacks clarity as a result. The proposed regulations already require that the health history questionnaire "be clear, specific, unambiguous and written to be understood by a reasonable layperson" (Section 2274.73(d) - we have suggested alternate language for "reasonable layperson" but the concept is the same). Thus it is not necessary to impose a subjective standard that is duplicative, creates ambiguity, and cannot, with certainty, be complied with. Instead, we would recommend the Department strike (4) and (5) and replace (3) with the following:	(3) - (6) establishes the means for an insurer and CDI to evaluate questions against these standards. These standards refer to outdated and outmoded types of questions used in older health history questionnaires using wording that tricked and confused applicants. Proposed substitute language does not offer a substantially different wording.

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(3) Include questions requiring the applicant to evaluate or understand the ~~significance of a physical symptom of the~~ cause of the physical symptom.

(6) The requirement lacks clarity and potentially prohibits the insurer from requesting information within the applicant's knowledge. An insurer is entitled to request information within their knowledge that may not be obtained through other sources, and is material to the insurer's evaluation of risk.

(7) Antivirals may be indicated in a medical record. They may be used for conditions other than HIV/AIDS. Are carriers banned from using this information?

(g) This provision would bar insurers from checking on whether their agents were appropriately assisting applicants, as required in Section 10119.3. Thus, it is inconsistent with existing law and should be struck.

2274.74 Standards for Avoiding Prohibited Postclaims Underwriting
(a) The standards outlined in this section "include but are not limited to" all the following requirements. Regardless of the title of this Section, the Department has not limited these requirements regarding what constitutes "complete medical underwriting" to what is required to avoid postclaims underwriting. The statute links and limits "complete medical underwriting" with the prohibition against postclaims underwriting. As the subsection is currently drafted, it is open-ended and applies to any and all applications, regardless if any questions arise. What would this mean in regard to a market conduct exam? If insurers do all that is required in the regulations, could the Department then tell them they did not do enough? This provision not only lacks clarity, but authority, both of which are required under Government Code Section 11340. As mentioned at the beginning of this letter, anything short of completely objective standards will only continue the confusion and litigation that these regulations seek to avoid.

ACLHIC would recommend the following changes to subsection (a):

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(6) If the insurer's request for information is reasonable and necessary to their underwriting process and is asked in a manner that meets the standards for health history questions, information that is within the applicant's knowledge is allowed by these regulations.
(7)Insurers are not banned from asking about conditions other than HIV/ AIDs where antivirals are used. They are banned from asking a direct question about whether antivirals are used since this is a prohibited solicitation of information.

2274.73 (g) does not bar an insurer from contacting an applicant as part of an inquiry as to whether agents are providing appropriate assistance. Its purpose is much narrower; it is intended to bar insurers from asking a question that requires the applicant to make a determination of assistance as specifically defined in these regulations.

Section 2274.74
See amended text of Section 2274.74(a) which established the obligation of the insurer to gathering necessary information "in order to complete medical underwriting". This term derives directly from one of the two pronged requirement of CIC 10384: to complete medical underwriting.

Section 2274.74(c) limits the applicability of the standards in this section to circumstances where the insurer seeks to retain the right to rescind, cancel or limit a policy or certificate. Therefore, the standards do not apply to all applications; but only applies to those applications leading to policies where the insurer seeks to rescind, cancel or limit in the future.

The proposed substitute language does not clarify the existing proposed regulation. In addition, the title of this section is part of the regulation itself and clearly states

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(a) "*For the purposes of avoiding postclaims underwriting, i*n order to complete medical underwriting prior to issuing a policy, the insurer shall obtain the necessary information to evaluate eligibility for coverage in accordance with the insurer's medical underwriting guidelines and determine the appropriate rate for the policy offered. This process shall include but not be limited to *making a reasonable effort to obtain, review and evaluate* the following ~~activities~~ by the insurer *as the facts and circumstances of a particular application warrant*:"	that Section 2274.74 sets standards for avoiding prohibited postclaims underwriting.
(1) Requires an insurer to obtain an applicant's PHR and then requires the insurer to evaluate and verify such information in subsections (3), (4), and (5) for accuracy, completeness and consistency. As PHRs are unreliable sources of medical information, which may be modified by the applicant, this criteria cannot be met with any certainty. The use of PHRs should be optional as a result. We would recommend the following language instead for this subsection: (1) The applicant's *health insurance questionnaire or other self-reported data, such as a* PHR, if available; (2) It should be noted here that most applications are submitted electronically. The wording in sub (2) should be revised as follows: "*Make reasonable efforts to obtain and evaluate externally verifiable* commercially available medical underwriting information for each applicant, *from at least one* ~~such as~~ *of the following:* commercially available claims *or application* data, claims data*bases* from prior insurers if available *or* ~~and commercially available~~ pharmaceutical *data* ~~information.~~"	(1) PHRs as defined in this regulation are not unreliable sources of information since they contain extracted claims information reflecting the individual's past utilization of health care services. It is standard industry-wide to use aggregated claims information as the basis for actuarial determinations and establishing medical underwriting guidelines. See change in amended text at Section 2274.74(a) which accomplishes the change as proposed by the commenter. See amended text for Section 2274.74(a) which requires an insurer to seek at least one source of health history information other than self-reported information , if available.
(3) Requires that medical records be pulled in all instances. This is very intrusive and costly and will greatly delay the decision by the insurer to provide coverage. Medical records are not necessary for review of every application, and the requirement to obtain medical records should be based on the objective and sound underwriting principles of the insurer, should a reasonable question arise in the underwriting process from the written information submitted on or with the application prior to issuance of the policy. As we stated in our comments under Section 2274.70 (a), the regulations should separate what is required for a rescission to occur from underwriting	Disagree. The original text never required that medical records be pulled in all instances. See amended text for Section 2274.74(a) for clarification of the minimum standard for the use of outside sources of health history information. The regulations have been clarified by stating that the standards for avoiding postclaims underwriting only apply if the insurer seeks to rescind, limit or cancel the

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that is generally required with every application. As the attached economic analysis shows, the average cost of ordering a medical record is around $50, and today it can take anywhere from 10-30 days or more to obtain a record. If one assumes that the average person has seen 3 to 5 providers over a ten year period, the cost of ordering records for a typical application for a family of four could add more than $600 to the application process, which will be reflected in annual premiums. As mentioned previously, this not only makes Department-regulated health insurers anti-competitive with their health care service plan counterparts regulated by the DMHC, it is very intrusive for the individual applicants and a burden to providers to respond to these increased demands for records. The proposed requirement does not take into account the delays in providing coverage in a timely manner to applicants, the added burden on provider practices and the undue burden and cost on insurers, which increases the cost of furnishing coverage in the individual market. The requirement is imposed even when no reasonable question has arisen from the written information provided on the application. ACLHIC would recommend the following substitute language for subsection (3): (3) *When a reasonable question arises from the written application,* reviewing and evaluating each individual applicant's health status and health history using PHR data and/or self-reported information from each individual's application in conjunction with other reasonably available sources of health history information for each individual applicant, including but not limited to the applicant's medical records or current or prior claims history with the insurer or its affiliates *based on the insurer's objective underwriting criteria*;	policy. These regulations only require insurers to obtain medical records to the degree necessary to obtain the detailed information required by their medical underwriting guidelines and if there's remaining questions from the application that require resolution. The text never required insurers to access medical records unless more detailed information was needed about the applicant based on either internal contradictions on the application or conflicts between self-reported health history information and health history information obtained from an outside source such as pharmaceutical data. The amended text of Section 2274.74(a) clarifies that it is the insurer's medical underwriting guidelines that largely govern the level of detailed health history information that is needed to complete underwriting. There is no evidence that delays in providing coverage will result if more robust underwriting is performed on a pre-issuance basis, especially if health history questionnaires are utilized.
(4) "Checking reasonably available health history information...for accuracy, completeness and consistency" is an open-ended subjective standard. It should be amended to state "*make reasonable efforts to resolve any inconsistencies found in health history information*." Insurers can only check those sources that they are aware of and should only be required to obtain medical records when inconsistencies or reasonable questions arise from the information provided. Also, the Department appears to be changing the definition again of layperson vs. layperson standard.	Disagree: Using terms such as "reasonable efforts" is too subjective and lacks sufficient specificity to set a consistent and measurable standard. Disagree. There is no conflict between the definition of a reasonable layperson standard and the standard established in Section 2274.74(a)(4).

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This further argues for using the alternative language proposed under Section 2274.72 (b). (5) "Verifying that the information submitted by the applicant" should be amended to read: "*Making reasonable efforts to verify*..." since some information may be unverifiable. A subdivision should be added to this section which states: *(8) "Nothing in this section shall preclude an insurer from declining an application based on the information included in the application, without further underwriting."* (b) Recommendation to strike "any necessary additional information" which is an open-ended, subjective standard, and substitute with "*information obtained under (a)."*	Reject. See comment above regarding the phrase "making reasonable efforts.." The Department assumes that insurers will expend reasonable efforts during their underwriting of applications making it unnecessary to constantly repeat this requirement. Further, the term is inherently vague and difficult to define. Disagree. The suggested provision (8) is unnecessary. These regulations do not bar an insurer from denying an application if the insurer determines that the applicant does not qualify for coverage. (b) This standard only applies if the insurer is pursuing resolution of conflicts that have arisen on the application or between information on the application and information received by the insurer from other sources. The amended text of Section 2274.74(a) clarifies that such information as referenced in this Subsection (b) is limited to "the degree necessary to assure that it has obtained the health history information in the detail needed."
(1) Strike "if an agent indicates awareness" – the agent is required to either sign the attestation or not. This seems to imply that the agent knew something was amiss on the application and signed the attestation anyway. This paragraph should require an agent to comply with CIC Section 10119.3. (2) Paragraphs (2), (3) and (4) appear redundant but could be interpreted as contradicting each other. Paragraphs (2) and (3) should be collapsed into one paragraph to avoid redundancy or confusion, and parts of (4) should be included into that one paragraph. Alternatively, there would be more clarity if subdivisions (3) through (6) are deleted and subsection (a) is referenced. (3) Paragraphs (2), (3), (4) and (5) include the terms "doubtful," "had doubts" or "did not understand." These should be stricken throughout the proposed regulation. These are very	Disagree with (1). Insurers routinely ask an agent to indicate if the agent is aware of anything about the applicant or application that the insurer should know about in order to complete its medical underwriting. This practice pre-dated the more recent agent attestation requirement which addresses only whether or not the agent assisted the applicant in completing the application. Paragraphs (2),(3) and (4) may include some overlapping activities but they are not contradictory rather they are complementary. All of these activities are aimed at underwriting that reconciles conflicting health history information obtained from different sources.

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subjective terms. Instead, the recommendation is to replace with "*not sure, don't know, or words of similar import"* – which could be used on the application as a catch-all rather than more subjective terms. (6) Again, the affirmative "the insurer shall obtain" should be amended to "*seek to obtain*." Subsection (6) (c) cites "a commercial pharmaceutical or medical information database." This should be consistent with our recommendations under 2274.74(a)(2) and thus read: "*Make reasonable efforts to obtain and evaluate externally verifiable* commercially available medical underwriting information for each applicant, *from at least one* ~~such as~~ *of the following:* commercially available claims *or application* data, claims data*bases* from prior insurers if available *or* ~~and commercially available~~ pharmaceutical *data* ~~information.~~"	(6) applies only to identified uncertainties, questions, conflicts or doubts arising from or on the application or if information received from other sources conflicts with self-reported information. See amended text for Section 2274.74(a) which requires that at least one source of health history information other than self-reported information be sought, if available.
(c) This section is over-broad and could result in consumers challenging regular rate actions on the basis that medical underwriting was not completed. Additionally, a request to change coverage may not be able to be honored because it raises the issue of whether medical underwriting was completed. Finally, although the Department's "Notice of Proposed Action" acknowledges an exception to these requirements for willfulness, the regulations fail to set forth this exception thereby making the regulations inconsistent with the statutes it seeks to clarify.	Comment is not comprehensible. There is no connection between a regular rate action and medical underwriting activities governed by these regulations The regulations do not implement statutes governing requirements for an insurer to allow changes in coverage without underwriting (the "free transfer" statute). Nor do these regulations affect regulations affecting health insurance rates (medical loss ratio rules). The intent standard that insurers must prove in order to rescind an insurance policy is governed by federal law. (See FSOR Update to the Informative Digest.)
Section 2274.75 Documentation Requirements and Examination by Commissioner (a) Authority is being cited from the wrong code section. Section 790.14 does not exist. Does the Department mean Section 791.14? In addition, insurers maintain their records electronically and any documentation subject to examination should be acceptable in electronic format. The reference to a requirement that information be documented in writing should be revised for consistency with today's business standards, comparable legal evidentiary standards, and environmental consciousness.	**Section 2274.75** Agree. Section 790.14 does not exist; this was a clerical error. It will be removed as a non substantive change and replaced with 791.14. See Section 2274.75(a)(6) which expressly acknowledges that all communications which includes any documentation subject to examination includes electronic records. There is nothing in these regulations that bar insurers from maintaining their records electronically; in fact this subsection expressly allows it under the

Verbatim Text of Comments	Response
(3) This sentence should be replaced with a cross-reference to the previous section about verifying completeness. (5) The regulations should not limit what types of communications from agents might be cogent. Recommend striking the entire sentence after "applicant" to read: "*All communications with the agent assisting the applicant*."	established framework of the Civil Code. (3) Disagree. This section concerns documentation requirements not prescriptive standard. (5) This subsection does not limit an insurer's use of agent communications in any way. This subsection merely lists the types of documents that are subject to examination by the CDI.
Section 2274.76 Agent Attestation and Notification Requirements When Health Insurance Applications are Submitted to Insurers This entire section would exceed the authority of CIC Section 10119.3, which imposes duties on the agent to assist an applicant in the application process. The only requirement in that section on insurers is to have the agent attestation with certain disclosures on its application. The requirement to assist the individual applicant and complete the attestation is on the agent. This section instead seeks to transfer the responsibilities imposed by the statute onto the insurer. Thus, this section should be revised to more accurately reflect the requirements imposed on the insurer, in order to meet the authority, consistency, and nonduplication requirements under Government Code Section 11340. Having stated that, we would additionally raise the following issues: (a) Notification of the insurer that an agent has provided assistance should be done through signing the attestation. Additional attestations should not be required upon submission of the application since no changes can be made to the application after submission. There should be a general provision that agents comply with Section 10119.3 of the Insurance Code. (e) The agent should be responsible for getting an attestation back to the insurer, including an unsigned attestation making it clear they did not assist. (f) Why is the insurer providing an agent with a copy of the application? The agent should	**Section 2274.76** Disagree. The insurer must obtain an agent's attestation as to whether the agent did or did not assist the applicant. This is already in place and attestation forms have been approved by CDI. While it's true that the statute imposes a responsibility on the agent to complete the attestation for the insurer; there is a parallel responsibility of the insurer to obtain the agent's attestation. These regulations do not bar an insurer from receiving notification of assistance by an agent through receipt of the agent's attestation. Since assistance by agents can continue beyond the time of submission of the application, if an agent does not initially assist, but assists the applicant AFTER the application has been submitted and is in the underwriting phase, insurers must be informed of post-submission assistance or this law would be easily undermined. Disagree. An unsigned attestation does not indicate anything and it certainly does not indicate that assistance was not provided.

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already have access to this through the website. (g) The whole section should be stricken. Even electronic or "ehealthinsurance" websites must submit an attestation already so it is not necessary to require all the additional notifications.	See above response as to why it is necessary that any post-submission assistance be subject to an agent's attestation.
Section 2274.77 Return of Completed Application for Health Insurance Coverage at Time of Policy Transmission; Notice and Communication Requirements (b) The regulations appear to require applicants to "immediately" contact the insurer if there are any discrepancies on the application. Insurers would instead give applicants a time certain to contact the insurer to correct the information. The regulations should instead provide a time certain for applicants to correct the record, after which the applicant would be bound, for purposes of rescission, by what was contained in the original application in the absence of any corrections.	**Section 2274.77** (b) Disagree. The term "immediately" indicates the urgency of the insurer's need to know if any self-reported health information on the application requires correction by the applicant. CDI has investigated cases where agents have illegally altered applications and submitted false health history information in the name of the applicant. In those cases applications were never returned to the applicants and those applicants didn't discover that their health history information had been illegally altered by the agent until receiving the rescission letter from the insurer.
(c) This subsection is missing the complete phrase from the statute, "or endorsed on" which is necessary to accurately reflect the standard established by the Legislature. In addition, the subsection should start with "*Absent any other legal basis available to the insurer, and insurer shall not use....*"	(c) Agree. See amended text change to (c) of Section 2274.77 and amended text change to (d) of this section adding the term " or endorsed on". Disagree. Suggested prefatory language is unclear and confusing and doesn't comport with the statutory requirement.
(d) The Department relies on *Ticconi v. Blue Shield of California Life & Health Ins. Co.*, 160 Cal.App.4th 528 (2008), to establish standards regarding the attachment of applications to policies when issued. The Department's reliance on *Ticconi* is misplaced. The *Ticconi* Court itself acknowledged that it was only addressing the procedural question of whether a class should be certified. Any other discussion from that opinion is merely dictum and does not establish law, and should not be relied upon by the Department. Notably, two California trial courts addressing Insurance Code Section 10381.5 – one before the *Ticconi* Court of Appeal ruling and the other after – reached a conclusion opposite of the dictum stated in *Ticconi*. In *Standard Ins. Co. v. Carls* (N.D. Cal. June 9, 2000) 2000 U.S. Dist. LEXIS 8401, 2000 WL769222, the court held that an insurer could satisfy Section 10381.5 if the application was "endorsed on" the policy when issued. That court found that Standard's policy incorporated the application into the policy by reference, and thus satisfied Section 10381.5 under California law. The similar result occurred in late 2008, in *Beevers v. Blue Shield of Cal. Life & Health Ins. Co*, Superior Court Case No.	Disagree.(d) The Department does not rely on *Ticconi v. Blue Shield of California Life and Health;* it relies on its interpretation of the statute and the Legislative intent and public policy purpose of the requirement to attach a completed health insurance application to the policy at the time it is issued and delivered to the insured. Superior Court cases cannot be cited as precedent for purposes of Reference for these regulations. Section 10381.5 use of the term "endorsed on" is unclear as to what is actually required of the insurer in this context since the health insurance application is part of the original insurance policy at the time of issuance. Unlike the Insurance Code's definition of Endorsement in Section 10274: " The term "endorsement" as used in this chapter means any amendment, change, limitation, alteration or restriction of the

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SCV238571, a rescission case in which the application was not physically attached to the policy when issued, but explicitly incorporated by reference into the policy. The trial court, with full knowledge of the *Ticconi* ruling, granted summary judgment in Blue Shield Life's favor on all issues, dismissing the action. The Department exceeds its authority in defining "attached to or endorsed on the policy" by limiting the definition in subsection (d) and standard in subsection (c) as it does. In addition, ACLHIC would suggest clarification regarding how applications are attached or endorsed when policies are delivered electronically. We would propose the following language at the end of this subdivision: *"If the policy is delivered electronically, the application will be considered attached or endorsed if the electronic communication includes instructions for viewing the application with instructions for viewing the policy, if the webpage that links to the policy includes a link to the application, or if the electronic delivery mechanism otherwise directs the insured to both the policy and the application."*	printed text of a policy by a rider upon a separate piece of paper made a part of such policy." The application for health insurance is not an amendment, rider, subsequent change to the policy after its issuance. Subsection (d) of this Section 2274.77 clearly allows for electronic delivery of the application at the same time a policy is electronically delivered in the phrase " or other delivery mechanism used at the same time.." The other delivery mechanism option covers electronic delivery. The point here is to make sure that both documents- the insurance policy and the health insurance application- are delivered at the same time, regardless of how that delivery is effected. If an insurer chooses to use a web-based delivery mechanism such as that described by the commenter, it is allowed by this subsection.
Section 2274.78 Post-Contract Issuance Rescission or Cancellation Investigations (a) There are many reasons to cancel a contract, other than claims investigations. The regulations should cite back to Section 10273.6 to ensure that all other lawful reasons to cancel a contract are available to the insurer. (b) Claims investigations not subject to these regulations should also cite CIC Section 10273.6, which allow investigations relating to fraud, criminal activity, disruptive conduct, failure to pay, and any other grounds that are standard provisions in contracts today. (c) This subdivision specifies that a review or investigation conducted by the insurer must commence immediately but in no event later than 15 calendar days from receipt of the information. "Immediately" is a subjective term. ACLHIC would instead suggest that the language state that *"the investigation shall commence upon opening the investigation."*	**Section 2274.78** Nothing in these regulations governs cancellation of a contract for reasons unrelated to claims such as failure to pay premium. Nothing in these regulations bars cancellation for non payment of premium, for example. Subsection (a) makes it very clear that this Section only applies to a certain type of claims investigation, not a non payment of premium investigation. See above comment. (b) There is nothing in these regulations that abrogates the applicability of CIC Section 10273.6 to claims investigations not subject to these regulations. In fact, if a post-issuance rescission investigation involves fraud, the proposed regulations apply to that investigation. Disagree.(c) Language suggested is circular, unclear and doesn't achieve the goal of establishing a reasonable timeframe within which a rescission investigation should

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In addition, this subdivision creates a new standard that limits an insurer's ability to open an investigation unless it receives medical or health history information that "reasonably raises a question" of misrepresentation or omission. This standard does not exist today, it is not tied to any law, and as written opens every investigation to scrutiny as to whether the insurer had the right to commence the investigation at all. It further establishes this standard without any clarification of what information could "reasonably raise a question" and would constitute a valid trigger for an investigation. Therefore, the entire first part of this sentence, "If an insurer receives medical or health history information about an insured after having issued health insurance coverage to the insured and such information reasonably raises a question of whether the insured misrepresented or omitted material information prior to issuance of the policy," should be deleted. (d) An investigation is not the same thing as a review. A review would be done in advance of an investigation to determine whether an investigation is even warranted. The term "review" should be stricken. In addition, it is not clear how this provision does not conflict with existing regulations at 2696.7(c)(2). (e) The written notice to the insured should describe the reasons for the investigation and the substantive information on which the investigation is based. Instead, the regulation requires that potentially large volumes of documents be sent to the insured in every instance. Insurers should instead be required to advise insureds in the notice that they may request a copy of any or all of it, and obtain it upon request. (f) The prohibition against the insurer seeking information that is not reasonably required or material to the resolution of the investigation could be subjective on the part of the regulator. Instead, it should read: "*...shall not seek information that the insurer believes is not reasonably required...*" Same change in the second sentence. The insurer should be able to seek records for which it has a good faith reason to believe are important to its investigation, but often the insurer can only determine the materiality of the information after it is received and reviewed. Further, the requirement that an insurer not request or obtain information directly from an insured could surely stifle a good faith effort at doing effective underwriting. What if a provider refuses to	begin once an insurer has received information. Disagree. There is nothing in this section that bars an insurer from commencing an investigation for reasons other than receipt of medical or health history information about an insured. See subsection (a) which identifies the types of investigations subject to these standards. Insurers use their own judgment daily to determine whether or not information, such as a claim or notice of a claim, causes them to decide to initiate an investigation. (c) simply requires them, when they make the receive such information to initiate the investigation within a specified timeframe. This regulation is needed to address the problem of insecurity by the insured whose coverage is at risk and delay by the insurer who unilaterally decided whether or not to investigate, when and how long it takes and when the insured's coverage will or will not be rescinded. (d) Disagree. The term "review" is used because some insurers don't investigate, they review. It's intended to cover both types of actions, should there be any material difference. The Department is not aware of any conflict with other regulations. The section cited by this commenter could not be located. (e) Disagree. The insured whose application and claims history is subject to a rescission investigation is entitled to all documents used in the insurer's investigation; she should not be required to request these documents. (f) Agree that an insurer's determination of why certain information may be required or material to resolution of the investigation may have an element of subjectivity as well as an examiner's review of the insurer's determination however the insurer can explain why certain information is material and required as often happens during exams by regulators. Insurers are not underwriting during the rescission investigation as underwriting is supposed to be conducted pre-issuance. If a provider refuses to supply information requested by an insurer, the regulation does not bar the insurer from asking the

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send the information? Instead, insurers should be able to ask an insured if other avenues to obtain the information fail. Finally, what constitutes delivery of a notice?	insured for it. Most insureds do not have their medical records however. The rule only requires the insurer to seek information from sources other than the insured if it can be obtained. If it cannot be obtained from another source, the insurer is allowed to ask the insured for it. The Insurance Code and regulations are replete with notice requirements with no express rules prescribing delivery of notice. Insurers have a variety of procedures to effectuate provision of notices that they rely on. Section 2274.75 specifies the documentation requirements subject to examination and includes communications relating to the processes in this article, which would include communications with the insured regarding any rescission investigation.
(g) 90 days may not be long enough to complete an investigation when the timeframe is dependent on the cooperation of others outside the insurer to obtain the necessary records and documents. The regulations should be amended to allow the timeframe to stop while the insurer is waiting to receive requested information. The requirement that an insurer show "good cause" for a delay should be defined to include such situations as an insured's failure to disclose personal health records, or not receiving the needed medical records from a provider. Additionally, it is not clear who good cause is demonstrated to, and therefore the phrase should be replaced with "*except for good cause*." A situation where an insured refuses to sign the needed authorizations to obtain the information, or otherwise prohibits the release of records to the insurer, should be grounds in and of itself for a rescission.	(g) The regulation provides for the circumstance where an insurer cannot complete the rescission investigation within 90 days or less. Since insurers are required to continue to pay claims since the policy remains in force, it is in the best interests of insurers to timely complete a rescission investigation. The "good cause" requirement is intended to protect the insurer during an examination. If the insurer can show good cause for lengthier than allowed time for completion of the investigation, the insurer will be compliant with these regulations.
This subdivision should exclude investigations related to fraud (Section 2695.7 of the Fair Claims Settlement Regulations) or provide a longer time period for fraud investigations.	CDI lacks statutory authority for treating rescission investigations which may subsequently prove fraud by the applicant/ insured differently than a rescission investigation that proves justified based on a different intent standard such as intentional misrepresentation of a material fact. In any event, the insurer would not know the ultimate intent of the applicant/insured until the completion of the investigation and as such having differing timeframes would prove unworkable in practice.
Also, it is not necessary to send a written notice to insureds every 30 days re-telling them that the insurer is continuing the investigation. It is not clear what the "detailed information" is supposed to contain in these subsequent notices. It is possible there would not be any "detailed information"	(g) Disagree. Insurers have been accused of dragging out rescission investigations making insured insecure about whether they actually have health insurance or not. An "every 30 day" notice requirement mirrors the requirements in place for non-

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until the investigation is concluded, yet the proposed regulations would require that "detailed information" be included in every notice, every 30 days. The initial notice, which is required to spell out the reasons for the investigation in the first place, and provide an opportunity for the insured to respond, should be adequate for the purposes of informing the insureds of the issues and allowing them an opportunity to respond. Finally, insurers who utilize an independent third party reviewer voluntarily or as approved under Corrective Action Plans with the Department would need an extra 30 days upon completion of their own investigation to allow the third party reviewer adequate time to review.	rescission related claims investigations and provides balance and fairness to both parties to the contract. Insurers who are using an Independent Medical Review system and need additional time beyond the 90 day time frame can assert their use of an Independent Reviewer as " good cause".
(h) The Department's use of "detailed findings" should be spelled out. Otherwise, this could be a completely subjective requirement.	(h) Disagree. Insurers who have completed rescission investigations in the manner prescribed by these regulations will know what detailed findings to include to justify and explain the basis for their final determination.
(i) As the Department knows, some insurers have already implemented a third party independent review of rescission decisions. Subdivision (i) would only allow the Department to review the decisions. While it is unclear why the Department would want to take on this role, at the very least the Department should identify appropriate third party reviewers and allow insurers and insureds this option at their discretion. Further, the regulations should state that internal appeals processes should be exhausted first prior to a third party review, as is the case under the Independent Medical Review System.	(i) The commenter misreads this subsection. This subsection merely re-states an insured's current right to file a complaint with CDI at any time regarding any aspect of coverage, including a rescission or a rescission investigation. CDI currently lacks statutory authority to identify third party reviewers and offer it as an option. Since rescission is such a serious action affecting an insured's coverage, it is not reasonable nor legally authorized to force an insured to pursue a private internal appeals process offered by the same insurer who rescinded coverage before seeking CDI review. CDI lacks statutory authority for restricting the right of an insured who has been notified of a rescission investigation from seeking assistance from the CDI at any time.
(j) The requirement that insurers comply with all other laws is obvious on its face and would in no way be abrogated by these regulations. It is unclear why this statement is necessary in these regulations, unless the department is somehow trying to tie unrelated statutes to the regulations in some fashion. This subdivision lacks clarity.	(j) Agree that it is obvious that insurers are required to comply with all other laws. However, the Department's examinations of insurer's rescission practices uniformly discovered that insurers were halting payment of all claims in violation of existing claims handling laws while often lengthy rescission investigations were undertaken. In addition, insurers were notifying providers in writing, while an insurance policy was in force, that no further claims were going to be paid. These actions are in direct violation of applicable laws thus making it (j) necessary to clarify existing law.

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CCR Title 10, Chapter 5, Subchapter 2
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Blue Shield Life & Health Ins. Co.(BSL&H) Andrea DeBerry 07/20/09	**BSL&H**
Section 2274.70 – The stated purpose of the regulations often exceeds CDI's authority by broadening the scope of statutes. The stated purpose subsections (a) and (e) — to regulate medical underwriting — needs clarification to make clear that the medical underwriting regulations apply only when an insurer is seeking to retain the right to rescind, cancel or otherwise limit the policy. *See Ins. Code* Section 10384. The proposed underwriting regulations should not apply when there is no issue pertaining to postclaims underwriting. The "Initial Statement of Reasons" is clearer on this point, noting at Page 3 that there is confusion and disagreement concerning "exactly what constitutes pre-issuance medical underwriting that would permit an insurer to legally rescind insurance coverage." Similarly, the Initial Statement of Reasons confirms at Page 8 that the proposed underwriting standards apply when the insurer is seeking to avoid prohibited postclaims underwriting. Unfortunately, the proposed regulations do not make that same point clearly, and should be amended to clarify that important scope limitation.	**BSL&H §2274.70** Agree that the postclaims underwriting requirements of the regulation apply only to insurance policies which an insurer seeks to rescind, cancel or limit. See addition to Section 2274.74(c) that has been made to clarify the application of these standards. The text of the regulation has been amended to clarify that the standards to avoid prohibited postclaims underwriting do not apply to policies which the insurer never undertakes to rescind, cancel or limit.
Section 2274.71 - The specific lack of ability to rely on the requirements set forth in the regulations defeats the CDI's rationale for necessity of regulation. Subsection (b) states that compliance with the regulations will not be viewed necessarily as compliance with the applicable laws. The CDI believes these regulations are necessary to establish requirements concerning the underwriting process, the application form, the rescission process, and agent attestation that the CDI estimates will cost insurers and the individuals they insure millions of dollars. Yet, this subsection eliminates all certainty and clarity by not allowing insurers to rely upon compliance with these requirements. To rectify this problem, this provision should be deleted and a safe harbor provision should be inserted.	**BSL&H §2274.71** There is no statute authorizing the Department to create the "safe harbor" requested by the commenter nor is there any other requirement for the Department to do so. These regulations benefit insurers by establishing much greater specificity and clarity as to the requirements for pre-issuance underwriting, questions on the health history application, investigations and execution of rescissions and agent attestation. CDI estimates of the cost to insurers of complying with these regulations noted that insurers who have previously completed rescission-related settlements with the Department such as Blue Shield Life and Health Insurance Company have completed their investment in more robust underwriting processes as outlined in these regulations. These regulations clarify and make specific the vague and general term " postclaims underwriting" thereby enhancing certainty facing insurers whose rescissions may be subject to Department examination.
Section 2274.73 – Standards are unduly burdensome and exceed scope of statutes	**BSL&H §2274.73**

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The CDI's regulatory powers extend to review of applications to ensure that they contain "clear and unambiguous questions designed to ascertain the health condition or history of the applicant" and that the questions are "reasonable and necessary" for purposes of underwriting. *Ins. Code* Section 10291.5(c)(1) and (2). The regulations in this proposed section exceed the CDI's powers in various respects, including, by way of example:	Section 10291.5 (e) expressly authorizes the Commissioner to adopt regulations to implement standards for health history questions on an application. The regulations do not exceed the scope of this statute or the other authorizing statutes since these regulations clarify, implement and make specific the insurer's inquiries into the health history of the applicant.
Subsection (a) requires use of PHR wherever possible. Nothing in the implementing statutes governing applications suggests any such requirement. Moreover, PHRs are inherently unreliable, as evidenced by the burdensome and expensive requirements imposed on insurers in Section 2274.74 to verify the information in the PHR.	Subsection (a) has been amended to clarify that the insurer's use of objective information supplied by a PHR is in addition to its use of self-reported health history information. Further, the regulations have been amended to further clarify that the definition of a PHR in these regulations expressly excludes any applicant-generated information, if it exists.
Subsection (b) limits the insurer only to questions on the application designed to ascertain medical information that is reasonable and necessary for underwriting. This overly narrows the scope of Insurance Code Section 10291.5(c)(2) which actually allows the insurer to ask questions "based on" medical information that is reasonable and necessary for underwriting purposes. If the regulation is to restate the statute, it should use the same terminology to avoid confusion in interpretation.	There is no real difference between the statute's limitation that an insurer must only ask health history questions "based on" medical information that is reasonable and necessary for medical underwriting and the regulation's requirement that the elicited medical information is reasonable and necessary for medical underwriting. The regulation does not narrow the scope of permissible questions.
Subsection (c) defines "reasonable and necessary" information (the statutory standard) as information that is "essential to the insurer's calculation of prospective risk". The two standards are not the same. A standard that limits an insurer only to "essential" information is more restrictive than allowed by statute. Furthermore, provided that the information being sought is communicated clearly and does not contravene any legislative mandate (such as questions regarding HIV), there is no reason why the CDI should require insurers to show that every application question is "essential" to risk calculation.	Subsection (c) is limited to questions about health history or health condition of the applicant. The regulation makes specific and clarifies the statute allowing "reasonable and necessary" information for medical underwriting by defining it as information essential to the insurer's calculation of prospective risk of the coverage requested. Indeed, medical underwriting is the process of quantifying and determining risks by examining medical and other information such as age. The statute itself limits the insurer to gathering information necessary to determine the risk of granting coverage. There is no real difference between health history information that is necessary vs. such information that is essential to determining the prospective risk.
Subsection (d)(1): the regulation requires that questions be written in a manner to be understood by a reasonable layperson. The regulations should clarify that insurers do not run afoul of this section by listing medical conditions or terms when there is no "non-medical" alternative for the term or condition.	(d)(1) CDI attorneys will continue to review health history questions in applications as they do currently. These regulations give insurers and CDI attorneys the flexibility they need to recognize that there are certain medical terms that cannot be

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Subsection (e) prohibits the use of compound questions; however, the regulations should provide an exception when the use of compound phrases are unavoidable. For example, a question may contain an inquiry into pre-existing conditions which has been defined by the legislature. Use of such statutory language could not be unclear or ambiguous. Much of this section imposes a series of requirements (*i.e.*, separate questionnaires or "not sure" options) that, while we may do anyway, is not tied to the CDI's regulatory power and creates standards that are unnecessarily and overly detailed for placing in a regulation. Much of this section does not relate to ensuring that questions are clear or that they are reasonable to underwriting requirements, which is the sole statutory mandate. Finally, subsection (g) forbids any question concerning whether an agent has provided assistance. There is no statutory authority supporting any such regulation. Furthermore, we do not understand why the CDI would want to limit such a question from being asked, when the applicant's response to such a question may be used to corroborate or validate a broker's attestation, or may assist the insurer in following up on any application inconsistencies if the insurer is aware that the broker participated in the application process.	adequately replaced by non-medical alternatives in health history questions. (e) See comment above. If a statute imposes the use of certain terms in a health history question that absolutely require a compound question, that statute would prevail over this regulation by operation of law. It is not necessary to state that compound questions are allowed if unavoidable. Further, CDI attorneys will continue to review health history questionnaires and if it is determined that a compound question is unavoidable, that determination can be made. If the health insurance application is part of the policy, as is the current industry practice, the commenter misapplies the statutory standard. Section 10291.5(a) includes a requirement that the Commissioner assure that all language of insurance policies can be readily understood and interpreted. Section (b)(1) of 10291.5 contains even broader language allowing the commissioner to disapprove a policy (including a health history questionnaire that is part of the policy) that contains " any provision.. which is unintelligible, uncertain, ambiguous or abstruse or likely to mislead a person…" The commenter is mistaken about the sole statutory mandate that applies to these regulations. The text describing standards for health history questions establishes exactly the kind of detail that regulations should contain to implement, clarify and make specific applicable statutes such as Insurance Code section 10291.5. Subsection (g) makes it clear that it is not the obligation of the applicant to make a potentially nuanced and difficult determination as to whether the agent has or has not assisted the applicant. Section 2274.76 sets out the specific requirements for determining under what circumstances an agent has or has not assisted an applicant. It is the agent's and the insurer's obligation to make this determination; this responsibility should not be imposed on the applicant. The commenter is not prohibited by this section from seeking corroboration or validation from the applicant regarding an agent's attestation; this section simply requires that the

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	determination of whether or not an agent assisted not be made by the applicant.
Section 2274.75 - Regulation exceeds scope of statute We do not believe there is authority that supports this section of the regulation. Insurance Code Section 790.04 is related to unfair and deceptive acts as defined in 790.03. Medical underwriting is not addressed in Section 790.03. Also, Section 790.14 is referenced but does not exist. Section 2695.3 addresses claims handling practices and is also outside the scope of authority that would provide authority to issue this proposed underwriting regulation. We are not opposed to a regulation that provides a guideline for the establishment of a reasonable underwriting process. But this particular section imposes documentation obligations that are simply too burdensome for what the CDI is seeking to achieve. These types of obligations would impose costs and delays that would be passed along to consumers.	**BSL&H §2274.75** Disagree. Section 790.04 expressly gives the Commissioner authority to determine which practices in the business of insurance are determined to be an unfair method of competition or an unfair or deceptive practice of insurance. This type of investigation is authorized by CIC Section 790.04. Postclaims underwriting leading to unlawful rescissions could clearly be encompassed by this section of the Insurance Code. Postclaims underwriting is also fairly easily classified as a 790.03(h) violation. Agree re: comment on 790.14. This reference is deleted as a non substantive change. Section 2695.3 sets file and record documentation requirements pertaining to claims. Here the authority applies to claims records included in a rescission investigation. It is widely known that either received claims or an insurer's notice of claim, often received through a medical management process, triggers a rescission investigation. The authority cited supports the file and record documentation requirements in the proposed regulation. Disagree re: burden.CDI finds that the documentation requirements outlined in this Section include the types of documents and information evidencing underwriting activities undertaken prior to issuance of health insurance coverage that is routinely generated and retained by insurer.
Section 2274.76 – Regulation exceeds scope of statute Blue Shield Life believes there is no statutory authority to support this proposed section by removing the responsibility imposed by the Legislature on the agent and broker, and transferring those obligations to insurers. In addition, certain aspects of the proposed requirement are excessive. For example, subsection (f) requires insurers who receive electronic applications to return to the agent a copy of the application. We do not believe that CDI should be involved in regulating broker customer service issues such as this, and we do not understand why this	**BSL&H §2274.76** Re: subsection(f), the insurer is only obligated to return a completed copy of the application to the agent IF the application is submitted to the insurer through the agent's website. This is essential because a directly submitted application through an agent's website lacks the required agent attestation which the insurer is required to obtain. This is not solely a customer service issue between the agent and the insurer since the statute implemented by this section requires the insurer to obtain the

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requirement is necessary. Moreover, it creates an artificial distinction between electronic and other applications. Subsection (f) should be removed. Similarly, subsection (g) is unnecessary. The broker has already completed an attestation. The additional steps contemplated in subsection (g) are redundant and unnecessary. Moreover, it also creates an artificial distinction between electronic and other applications.	agent's attestation. Subsection (f) is necessary to address the reality of how agent's websites provide a vehicle for direct submission of applications by applicants to insurers via the agent's website. Subsection (g) is necessary when an application has been submitted electronically directly to the insurer via the agent's website, it will not contain an attestation as required by CIC 10119.3. This section is essential because it spells out the agent's attestation obligation under various scenarios when an agent provides assistance to an applicant, even after submission of the application to the insurer, as can occur.
Section 2274.77 – Regulation exceeds scope of statute Subsection (a) requires return of a copy of the completed application to the insured attached to the policy. First, Insurance Code Sections 10113 and 10381.5 do not apply to application statements. Those provisions require insurers to properly integrate any collateral materials that add or change the terms of the contract through certain procedures. Those contract integration procedures have no relevance here, because an applicant's application statements are not part of the contract between the insured and the insurer. They are pre-contract representations made to induce the insurer to form the contract. The proposed regulations also improperly cite to the Ticconi case as authority for the proposed regulations. However, as the Ticconi Court itself stated, that decision solely addressed the procedural question of whether a class should be certified. In that capacity, the Court could not address, and expressly said it was not addressing, the merits of the statutes, including whether they applied and if so what they mean.3 Because the applicability and meaning of these statutes was not at issue, and the merits had yet to be determined, the Court was required to assume for purposes of class certification that the statutes applied; and the Court's task was to determine whether a class could be certified based on the plaintiff's theory of the case. Thus, Ticconi did not decide and cannot be cited as authority for whether the integration statutes apply, and if so, what they mean. "Cases are not authority for issues not in dispute." American Civil Rights Foundation v. Los Angeles Unified School District, (2008) 169 Cal. App. 4th 436, 449-450.	**BSL&H §2274.77** This section limits the requirement to return the application only if the insurer issues the insurance policy. This is precisely because the application becomes part of the insurance contract at the point of issuance and delivery. This is the purpose of the referenced statutes- CIC 10113 and 10381.5. Once the insurer decides to issue the policy, the application becomes part of the insurance contract which is why the statutes require attachment or endorsement on the policy. Reference to *Ticconi* has been removed from the amended text because the CDI relies on its interpretation of the attachment requirement stated in CIC 101381.5 independent of *Ticconi.* However, CDI disagrees with commenter's representation of the *Ticconi* decision. The *Ticconi* court was required to construe and apply CIC 10381.5 as part of its ruling on the class certification. The Nieto court confirmed that *Ticconi* applied when it applied *Ticconi* but found that the statute's exception "in the absence of fraud" precluded the statutory attachment requirement in this particular case. Superior Court decisions are not precedential nor binding. If the facts in the cited case involved fraud, the attachment statute contains a fraud exception which would apply making the case inapposite to general non-fraud situations.

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Indeed, in a recent rescission action involving Blue Shield Life, the Sonoma County Superior Court flatly rejected the argument that the attach/endorse statutes even applied to application representations, or that the Ticconi decision had resolved that issue. That Court stated: "the insured argues that the application was not attached to the policy when it was issued, or otherwise endorsed on that policy. Insurance Code sections 10381.5 and 10113. The court finds that the "endorsed on" language does not apply in the current context, but, if it does, the insurer satisfied any requirements that the policy, itself, reference the applicant's health representations. The case of Ticconi v. Blue Shield of California Life & Health Insurance Company (2008) 160 Cal.App.4th 528 is not authority to the contrary." Beevers v. Blue Shield Life & Health Ins. Co., Case No. SCV238571 (April 23, 2009).	The amended text in Section 2274.74 (c) clarifies that if an insurer never seeks to rescind, cancel or limit a policy, the prescribed underwriting standards would not apply. Clearly, if an insurer never seeks to rely on statements made in a health insurance application, this regulation- requiring attachment- would not apply. However, the statute requiring attachment of an application to the policy does not make exceptions for situations where an insurer later chooses not to rescind, cancel or limit a policy, therefore the regulation does not exceed the terms of the statute itself. Subsection (c) of 2274.75 has been clarified to clarify that the statutory term " endorsed on" is included. However, the lack of clarity as to what exactly the term " endorsed on" means in this context is clarified in Subsection (d). Clearly, the term "endorsed on" as used in CIC 10381.5 is not consistent with the CIC 10274 definition of Endorsement.
Furthermore, even if the integration statutes did apply here, they would only require insurers to attach or endorse applications if the insurer later wished to bind the insured to the statements. Subsection (a) requires the insurer to attach the application in all cases, even if it does not later wish to use the statements. As such, the requirement well exceeds the statutory authority, even assuming the statutes applied to pre-issuance application representations. Subsection (a) also exceeds the reach of the statutes, which permit insurers to attach or endorse applications. Subsections (a) and (c) ignore the alternative requirement permitting the insurer to endorse the application. Subsection (b), which requires insurers to advise applicants to contact insurers with any discrepancies once they receive a copy of their application is not tied to, or authorized by, any particular statute, and is therefore improper for purposes of regulation. Insurers may well do this as a matter of policy, but it is not a proper subject for regulation. Subsection (c) also states that the consequence of failing to attach the application is that the insurer "shall not use" the information to assert a material misrepresentation or omission. Again, that does not track the statute. The consequence under section 10381.5 would be that an insured would not be "bound" to the answers in the application, but instead would be afforded the	Subsection (b) is clearly tied to one of the several purposes of the attachment requirement; namely, to make sure that there has not been any unauthorized alteration of the application by an agent or the insurer itself after the application was submitted for underwriting. The Commissioner has received consumer complaints regarding this practice of agents illegally altering applications and finds it necessary to build in this commonsense check. It is the best interest of the insurer to receive timely notification from an applicant if the application submitted has been illegally altered by an agent.

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opportunity to assert that they included errors that would have been corrected. The statute does not say that an insured's application statements cannot be used even when the insured subsequently application contained errors that would have been corrected on further review, had it been attached or endorsed. The statute does not say that an insured's application statements cannot be used even when the insured subsequently claims that they were not made in error and then takes the position that they were accurate. The proposed regulation would not serve any statutory purpose in a case where the insured has affirmed the accuracy of the application and has taken the position that the application would not have been changed or corrected on further review. Section 10381.5 (assuming it applies) would permit the insured the option to change her application answers in subsequent litigation (i.e., to not be bound to them) if the evidence is that the application contained errors that would have been corrected on further review, had it been attached or endorsed. Finally, subsection (d) equates the requirement to "endorse" (assuming it applies at all) with including a complete copy of the application along with the policy. Again, while we do in fact attach applications, we note that the proposed regulation misreads the legal option to endorse. The statutory purpose is to give the insured fair notice of the terms of the contract. When the document is the insured's own statements that she has already seen, reviewed and signed, fair notice is accomplished by fully advising the insured as to how those statements will impact the contract. This can be accomplished through means other than returning a copy of the application with the policy, which is the only option permitted by the proposed regulation. Again, the Beevers decision, noted above, reviewed this exact issue and found that it could be satisfied by means other than including a copy of the application with the policy. **Section 2274.78 –Requirements unduly burdensome and not necessary** The CDI's efforts to dictate the particular aspects of rescission investigations is not linked to any particular statutory requirement, and as such is an improper subject for regulation. Moreover, some of the proposed requirements would have detrimental effects. Subsections (d) and (e) require insurers, for example, to notify insureds within seven days of commencing any review, and to provide the insured with all documents being utilized. While BSL does not have any particular concern with notifying insureds of an investigation and seeking their responses at	Disagree. There is nothing in the statute requiring the insurer to afford the opportunity to the applicant to correct errors. Certainly an applicant may want to correct errors and the insurer may ask the applicant to correct errors; but these options are not related to this statute nor the regulation implementing this statute. A logical clarification of the statute's proscription against use of the statements by the insurer is the proposed regulation that the insurer shall not use information (e.g. statements) on the health insurance application as the basis for rescission. The scenario described by the commenter is not prohibited by the proposed regulation. (d) The commenter incorrectly equates endorsement, as defined in CIC 10274, with the referenced statute's term " endorsed on" . There is nothing in the referenced statute that indicates that the health insurance application is equivalent to an amendment, change, limitation, alteration or restriction of a policy or a rider upon a separate piece of paper made a part of such a policy as defined in CIC 10274. The term " endorsed on" in the referenced statute is unclear and the purpose of this regulation is to clarify that endorsed on in this context means the same as attached. The commenter does not clarify what means other than attachment would satisfy the purpose of the statute. Disagree that the sole purpose of the statute is to give the insured fair notice of the terms of the contract; if that was its purpose, the requirement to " attach" would be superfluous. **BSL&H §2274.78** This Section, 2274.78, of the regulation is referencing claims related investigations and possible rescission of policies which is subject to CIC 10384. As such, it is well within the authorizing statutes governing claims investigations. Re: notification of insureds, CDI finds that insureds who are covered have the right to know whether their coverage is under investigation or not within a reasonable amount of time. Seven days within the commencement of a rescission investigation

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an appropriate point when medical records have confirmed a likely non-disclosure, the timing proposed in the regulation would require blanket notice at a far earlier stage where the vast majority of investigations will not r esult in a proposed rescission. This will result in notifying numerous insureds are not in serious risk of rescission. At a minimum, insurers should be permitted to conduct a preliminary review and make a determination that the investigation should not be terminated before being required to notify the insureds, to avoid creating needless anxiety for many insureds where the investigations would not proceed further. We note, as well, that subsection (c) is imprecise and confusing. For example, it discusses when an investigation must commence after an insurer receives information that "reasonably raises a question of whether the insured misrepresented or omitted material information prior to issuance." Is the Department suggesting that there is some statute that requires the equivalent of "probable cause" to initiate an investigation? We are unaware of any such statute or other requirement under the law to initiate an investigation. To the extent that this proposed regulation is attempting to create such a standard, it is not properly the subject of a regulation. Blue Shield Life appreciates the challenges facing the CDI in developing these regulations and we remain willing to work collaboratively toward finalizing a regulation that provides clarifications to these processes. However, we strongly believe that the currently proposed regulations would result in an incredibly costly and unworkable regulatory scheme that does not adequately provide clarification to existing law that can be relied upon by health insurers. We believe a regulation can be developed that achieves that clarity, and that balances the desired consumer protections against those same consumers' need for available and affordable individual health coverage.	or review is a fair requirement balancing the rights of the insured against the needs of the insurer. CDI believes that insureds may have information essential to an insurer's investigation and the sooner the insured is informed of such an investigation, the sooner the insurer could receive information from the insured. The regulation provides significant discretion to the insurer to make the determination as to whether the claims information received " reasonably raises a question of whether to rescind or cancel the policy." This broad statement provides maximum flexibility to the insurer to determine whether or not to initiate a claims investigation involving a possible rescission. This statement describes current industry practice as to what triggers a rescission investigation. It is not a statement of a " probably cause" requirement. (c) The Department is not requiring probable cause; the Department is setting a requirement that discourages the insurer to sit on its hands and delay a rescission investigation once it has received information that would otherwise trigger an investigation. It is also not a requirement to investigate; it's a requirement to make a decision either to investigate or not without undue delay. This comment does not address any specific text of the proposed regulation.
Ca. Assoc. of Health Underwriters (CAHU) Steve Lindsay 06/29/09	**CAHU**
1. 2274.72(b) Reasonable layperson standards: While we share your desire to simplify the medical questions creating a new untested definition creates more problems that it is worth. The breadth and lack of specificity leave it open to anybody's opinion and without multiple court cases to narrow the definition it only serves to invite law suits. We would suggest as an alternative	1. Disagree. The "reasonable layperson standard" is not a new legal standard. It is already used by insurers in their adjudication of emergency services claims as required by federal law. Insurers must apply a reasonable layperson standard in determining whether an insured was reasonable in using emergency room in a

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using the Flesch-Kincaid readability of disclosure notices. It is included in all copies of Microsoft word. In addition remove all references to the "Reasonable layperson standard" from the proposed regulations.	particular situation. It is a highly appropriate standard to be used in the context of an insurer posing clinically based health history questions to a non-clinical applicant.
2. 2274.73(d)(3) In section 2274.73(d)(2) you require specified time periods for each question. In the next section 2274.73(d)(3) you use the word "recent" which is a different standard with no definition. The restriction included in Section (2) are more than sufficient to achieve the goal of making the look back periods as short as possible.	2. Subsection (d)(2) will place the necessary constraints on the look back periods of health history questions. The use of the word "recent" is constrained by the overriding rule that insurers are allowed under Section 2274.73(b) to ask questions that are reasonable and necessary for medical underwriting.
3. 2274.76(b) You reference "broker". In Insurance Code Section 1623(c)(1)(2) and (4) rebuts the presumption of broker as individuals transacting insurance are appointed as an agent who has no written agreement allowing the agent to accept a risk for an insurer. As agents they cannot appoint other licensees as agents of the insurer and we are not authorized to pay claims. These effectively make all insurance transactions by agents not brokers.	3. Agree with the comment for health insurance sales only. Brokers can sell other types of insurance however. All insurance transactions involving health insurance are by agents. The use of the term " broker" is included because the statute implemented here, Section 10119.3 uses the term " broker". However, a broker can operate a website for agent's use in selling health insurance. While it is the broker's website, it is the agent's sale of health insurance. Hence, the use of the term" broker" in connection with website.
4. 2274.76(c)(4) Agents should not be allowed to enter information directly into or onto any application ever. This should be a prohibited activity.	4. Agree. The Department is aware that agents do in fact enter information directly into or onto applications; hence the regulation is necessary.
5. 2274.76(c) We would like to see clarification that assisting an applicant includes both oral and written information. In the event the application is completed online and submitted over the internet any written information provided in writing by an agent should be included in the definition of assisting.	5. The regulation is written broadly enough to cover both oral and written communications. (c)(4) covers any written information provided in writing by an agent in the definition of assisting.
6. 2274.78(c) We are in agreement the applicant should not be held accountable for facts unknown to them. We are NOT in agreement that the insurer should ascertain whether the applicant understood the significance of the information. If underwriting is based upon facts then whether the applicant understood the significance of the information is immaterial to the underwriting outcome. It creates an unlevel playing field to hold insurers to facts but allow applicants to apply a different standard in their defense. The applicant either took the prescription or they didn't. If they are unclear what the reason was they should report their lack of facts on the application and the insurer can do more investigation to unearth the facts in order to complete the	6. AGREE. The text of the regulation has been amended to delete the requirement that the insurer ascertain that the applicant appreciated the significance of the information requested because this requirement has been supplanted by new federal law enacted on March 23, 2010, the Patient Protection and Affordable Care Act of 2010. Section 2712 of that Act established the requirement that the insurer may only rescind health insurance upon proof of intentional misrepresentation of a material fact or fraud. See Amended Text for this section which deletes the last sentence.

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underwriting process. 7. 2274.78(i) Allowing the applicant to file an appeal for rescission with the Department prior to completing the insurers internal appeal process if they have one is a waste of Department resources. The Department will use the resources to what end if the insurer's internal review process finds the rescission was in error and cancels it. The Department should review the insurer's internal review process for appropriateness and legality but stay out of specific insurer's review process until there is actually a rescission.	7. The commenter misreads this subsection. This subsection merely re-states an insured's current right to file a complaint with CDI at any time regarding any aspect of coverage, including a rescission or a rescission investigation. CDI currently lacks statutory authority to identify third party reviewers and offer it as an option. Since rescission is such a serious action affecting an insured's coverage, it is not reasonable to force an insured to pursue an internal appeals process offered by the same insurer who rescinded coverage before seeking CDI review. CDI lacks statutory authority for barring an insured who has been notified that a rescission investigation has been undertaken from seeking assistance from the CDI at a time of their own choosing.
Ca. Assoc. of Marriage & Family Therapists Catherine Atkins 07/01/09 Although the majority of the proposed regulations are commendable and directly address the problem of post claims underwriting, Sections 2274.78(a) and (b) lack the requisite clarity mandated by Government Code §11349.1. Sections 2274.78(a) and (b) are intended to address the issue of post-contract issuance rescission and cancellation investigations. However, the language, as written, is very unclear as to the intent and purpose of both (a) and (b), as well as the situations (a) and/or (b) directly address. Subsection (a) states that it is intended to apply to situations wherein the insurer is evaluating whether to "rescind or cancel the policy where the insurer …received a claim." It is unclear how a provider's claim for payment would have any affect on whether the insurer is engaging in post-claim underwriting? If the insurer has completed their underwriting process and issued a policy, why would a provider's claim for reimbursement thereafter trigger a need for rescission evaluation? Moreover, the Initial Statement of Reasons ("ISOR") for subsection (a) explains that where the insurer is evaluating whether to rescind, "the proposed regulations concerning the rescission investigation apply." What regulations? Subsections (c) through (j), but not (b)? Subsection (a) is written so unclearly, it is guaranteed that no reasonable lay person will be able to	**CA. ASSOC. OF MARRIAGE AND FAMILY THERAPISTS** The commenter has misinterpreted this section of the regulations to apply to providers. Subsection (a) applies to claims investigations undertaken for the purpose of determining whether to cancel or rescind a policy of an insured. It does not apply to provider claims. Subsection (a) identifies the types of investigations subject to these standards. Insurers use their own judgment daily to determine whether or not information, such as a claim or notice of a claim, causes them to decide to initiate an investigation. The commenter appears to be unaware of the practice on the part of some insurers to cancel or rescind an insureds policy once a claim is filed. This practice will usually occur well after underwriting has been completed. The commenter is correct that subsections (c) through (j) do not apply to claims investigations undertaken for other purposes such as interpreting policy provisions to determine pre-existing conditions or non-payment of premiums.

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understand the content, intent or purpose behind the section. Subsection (b) goes on to state that "The provisions…that follow Subdivision (b) do not apply to claims investigations not intended to…serve as the basis for an evaluation…of whether to rescind or cancel the policy." Does that mean that subsections (c) through (j) do not apply to (b)? In addition, subsection (b) gives examples of what (b) does not include (i.e., investigations of pre-existing conditions), but what <u>does</u> (b) cover? Like subsection (a), subsection (b), is open to multiple interpretations and written in a particularly unclear manner.	Subsection (b) states that the requirements in section 2274.78 do NOT apply to claims investigations initiated for any reason other than determining whether to cancel or rescind a policy. It provides examples of other types of claims investigations that are not governed by section 2278.74 requirements. Nothing in these regulations governs cancellation of a contract for reasons unrelated to claims. Nothing in these regulations bars cancellation for non payment of premium, for example.
California Medical Assoc. (CMA) Armand Feliciano 07/17/09	**CMA**
I. Similar to health plans, health insurers must also demonstrate that the applicant intentionally or willfully misrepresented material information prior to rescission of a policy. We, therefore, recommend deletion of the knowing standard, and adoption of the italicized and underlined amendment discussed below. Relying on Health and Saf. Code § 1389.3, the *Hailey* court concluded that health plans are precluded "from rescinding a contract for material misrepresentation or omission unless the plan can demonstrate the [] misrepresentation or omission was willful …." (*Hailey v. California Physicians' Service,* supra, at p. 459.*)* While we recognize that Insurance Code § 10384 has similar language as Health and Saf. Code § 1389.3, it lacks an express willful mental state standard. Nonetheless, we believe Insurance Code § 790.10 allowing the Insurance Commissioner to promulgate rules as necessary along with Insurance Code § 10291.5 prohibiting unfair trade practices provide sufficient general authority to DOI to adopt an intentional standard. In the alternative, DOI can simply delete "whether" and "or unintentional" from the existing Insurance Code § 331 (describing the effect of concealment) via regulation, which would then establish an intentional standard.	**I.** CDI lacks statutory authority to adopt the commenter's suggested "intentionally or willfully misrepresented material information" standard as a perquisite to rescission. The recently enacted federal law, the Patient Protection and Affordable Care Act of 2010, adopted a similar "intent" standard which under federal law all insurers will be required to follow as a pre-requisite to any rescission. Since this part of federal law pre-empts any state case law, the federal intent standard applies to California insurers seeking to rescind an insurance contract. Nothing in the proposed regulations contradicts the federal standard.
In truth, the stakes are extremely high for patients when health insurers rescind their health coverage that it warrants the higher intentional standard. Stated differently, if patients are to be saddled with huge medical debts when they are most vulnerable (sick or hospitalized), and if	CDI lacks the requisite authority to require the intent standard suggested by this commenter.

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patients are likely to be denied health coverage from other carriers after a rescission, then the burden should squarely lay on health insurers to prove that the patient intentionally misrepresented material facts as drafted below: Section 2274.78 (c) If an insurer receives medical or health history information about an insured after having issued health insurance coverage to the uninsured and such information reasonably raises a question of whether the insured *intentionally* misrepresented or omitted material information prior to issuance of the policy …. As used herein, an applicant's misrepresentation or omission of material health information on the application for health insurance must be *intentional as demonstrated by the insurer* ~~of facts known to the applicant and the insurer must ascertain that the applicant appreciated the significance of the information requested.~~	See above response.
From a public policy standpoint, adopting an intentional or willful standard in the proposed regulations will provide patients who purchase health insurance products the same level of protection available to patients who purchase health plan coverage, and avert confusion on what health plans and insurers must prove when rescinding patients in the Knox-Keene and Insurance Code side, respectively. Furthermore, a uniform standard will discourage health plans and insurers from regulator shopping in order to avoid an intentional or willful standard.	Recently enacted federal law has established the standard requested by this commenter. See Updated Informative Digest.
II. In the alternative, if DOI declines an intentional standard, then Section 2274.78 (c), "Post-Contract Issuance Rescission or Cancellation Investigation," must be clarified. Health insurers must know that they cannot merely rely on medical records when rescinding and that the knowing standard set forth in this section cannot be applied by insurers without contacting the insured during the investigation. We, therefore, recommend adoption of the italicized and underlined amendment discussed below On DOI's Notice of Proposed Actions page 15, it clearly specifies what health insurers must do when rescinding health policies pursuant to Section 2274.78 of the proposed regulations. We think these required steps must be specified in Section 2274.78 to ensure that they are binding on health insurers when complying with the regulations.	**II**. CDI lacks the statutory authority to make the detailed prohibition of relying on medical records as suggested by the commenter. An insurer must have sufficient information and evidence of intentional misrepresentation of a material fact or fraud committed by the applicant before rescinding under newly enacted federal law. It is this burden of proof that will dictate how insurers use medical records in defending any individual rescission. Section 2274.78 proposed regulations regarding the timing, notice requirements and conduct of rescission investigations will be binding on insurers, once adopted.
Section 2274.78 (c) If an insurer receives medical or health history information about an insured	The comment addresses the applicable evidentiary standard of proof in a rescission

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after having issued health insurance coverage to the uninsured and such information reasonably raises a question of whether the insured misrepresented or omitted material information prior to issuance of the policy …. As used herein, an applicant's misrepresentation or omission of material health information on the application for health insurance must be of facts known to the applicant and the insurer must ascertain that the applicant appreciated the significance of the information requested. *In complying with this standard, the insurer is not permitted to simply compare the doctor's notes in a medical record to the information supplied by an applicant on the application. Further, this standard cannot be applied by an insurer without first contacting the insured during the investigation.*	case. This will depend on the facts and circumstances of any individual case and the application of the newly enacted federal law which sets the intent standard required for rescission.
III. Specific patient protections must be included in the rescission written notice provided in Section 2274.78 (e), "Post-Contract Issuance Rescission or Cancellation Investigation." We, therefore, recommend adoption of the italicized and underlined amendment discussed below. The written notice set forth in Section 2274.78 (e) provides that health insurers must specify the reason for the investigation, substantive information which the investigation is based, and applicable documents (e.g., medical records). However, it does not specify what patients can expect during the rescission process or what they are entitled to. In our view, it will be helpful for patients to know that health insurers cannot simply compare the doctor's notes in a medical record to the information supplied by an applicant on the application. Also, they should know that insurers will be contacting them during the investigation to ascertain that the "misrepresentation or omission of material health information on the application for health insurance must be of facts known to the applicant and the insurer must ascertain that the applicant appreciated the significance of the information requested."	**III.** CDI lacks the statutory authority to specify the allowable uses of doctor's notes in medical records as part of a rescission investigation. The use of doctor's notes in medical records in a rescission case will vary depending on the facts and circumstances of the case and how the insurer attempts to meet the burden of proof imposed by federal law.
Additionally, patients should be notified that they have the right to be represented by a lawyer during the investigation. Because a rescission investigation will include specific allegations of misrepresentation, it makes sense that the patient understands the meaning of these allegations and their rights from a legal advocate representing them. In all fairness, health insurers will have many professionals, possibly including a health insurer lawyer, reviewing the rescission, and thus it is only fair that patients are aware that they can retain their own legal advocate during the rescission	Requiring insurers to notify insureds of their right to be represented is beyond the Department's authority.

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investigation. Perhaps of most importance the written notification should include a general statement indicating that patients will continue to have health coverage until it is determined that the policy is either rescinded or cancelled. Patients should feel confident that there medical needs will continue to be satisfied even if the issue of rescission is pending.	The proposed regulations are very clear that claims and coverage must continue in force during the rescission investigation. See Section 2274.78(j). CDI believes that such notice to the insured is not necessary.
Section 2274.78 (e) In the required written notice to the insured described in subdivision (d), the insurer shall clearly describe, in lay terms, the reason for the investigation and the substantive information on which the investigation is based. The insurer shall include with the notice copies of any *and all* applicable documents, such as claims, medical records, or any other information…. *The written notice shall also include the following admonition: In complying with this investigation, the insurer is not permitted to simply compare the doctor's notes in a medical record to the information supplied by you on the application. Further, the insurer or its representatives will be contacting you to determine whether the alleged misrepresentation or omission of material health information on the application for health insurance were facts known to you and that you appreciated the significance of the information requested and intentionally misrepresented or omitted such facts. You have the right to retain legal counsel at your own expense to represent you during the investigation. If you plan to have or unsure of legal representation, please contact your local or California Bar. You should know that the insurer is required to continue to authorize and provide all medically necessary health care services required to be covered under your policy until it is determined that the policy is rescinded or cancelled.*	CDI lacks statutory authority to require this type of detail in a notice to the insured.
IV. DOI must approve the insurer application to ensure that standards for health history questions on applications are compliant with Section 2274.73. We, therefore, recommend adoption of the italicized and underlined amendment discussed below. As drafted, Section 2274.73 requires health insurers to hold applicants to the reasonable layperson standard, to ask clear, specific and unambiguous questions, and to avoid compound questions etc. These are good standards for patients, but CMA requests that they be strengthened by requiring insurers to submit the revised applications to DOI for approval.	**IV.** Disagree. CDI does not need additional regulations to approve applications for health insurance since that statutory authority is in place. See CA Ins. Code Section 10291.5.

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Section 2274.73 (h): All revised individual health insurance applications pursuant to this section must be reviewed and approved by the commissioner before they may be used by a health insurer.	
V. Health insurers must not be allowed to pass on costs of obtaining medical records for purposes medical underwriting to patients or physicians. We, therefore, recommend adoption of the italicized and underlined amendment discussed below. As drafted, Section 2274.74 makes numerous references to health insurer obligations to obtain necessary information from external verifiable sources such as medical records. CMA supports requiring health insurers verify a patient's health information prior to issuance of a health policy.	**V.** CDI lacks the statutory authority to regulate the costs of obtaining medical records for the purpose of medical underwriting. The economic terms for the transaction between doctors and insurers regarding the provision of medical records by the doctor or hospital to the insured is a matter of private contract.
However, health insurers must bear any costs associated with verification of patient information during the medical underwriting and resolving of all reasonable questions process. It is also well documented that many statutory and regulatory mandates on health insurers are frequently passed on to physicians via contract—this must be avoided. Rescission is a product of health insurers' failure to conduct their medical underwriting up front; and therefore, the regulation is solely their mandate to carry out. While physicians see the value in providing medical records of their patients during the medical underwriting process if appropriate, it is important to note that obtaining these medical records cannot be used as another way to leverage physicians in contract negotiations.	CDI cannot bar this type of contractual agreement if the parties choose to pursue such an arrangement.
Section 2274.74 (d): All costs associated with verification of patient information during the medical underwriting and resolving of all reasonable questions process specified in this section shall be borne by health insurers. Nothing in this section shall allow insurers to contractually require physicians to produce medical records of their patients for purposes of medical underwriting or resolving of all reasonable questions prior to issuance of a policy to the insured.	
VI. An independent review process is warranted in light of the inherent and inescapable conflict of interest that health insurers have in determining whether to rescind policies. DOI must support legislative efforts to establish an independent review process in rescission cases and commit to amend the proposed regulation to include an independent review process should legislative authority be granted to DOI. We, therefore, recommend adoption of the	**VI**. CDI lacks the statutory authority to impose an independent review process on insurers who choose to rescind. This is a legislative matter not a matter for an executive branch agency to implement.

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italicized and underlined amendment discussed below. It well established that there are certain health care issues that simply cannot be left into the hands of health insurers, and that is why California has an independent medical review process whenever a patient is denied medical coverage. Currently, and as proposed by these regulations, the final arbiter of whether a patient's policy should be rescinded is the health insurer. This is unacceptable because health insurers stand to financially benefit whenever a patient's health policy is successfully rescinded—this is an inherent and inescapable conflict of interest on health insurers. The time for an independent review process prior to the rescission of a patient's policy is now to ensure that health insurer sharp business practices of illegally rescinding patient health coverage after he or she files an expensive claim cease and desist. From a public policy standpoint, an independent review process will not only bring fairness to the rescission process, but it will also bring transparency; with an independent review process, California can keep a record of the type of cases that are typically proposed to be rescinded, the amount involved, and outcomes of the rescission cases by specific health insurers.	
CMA recognizes that DOI has no current statutory authority to establish an independent review process in rescission cases. However, we urge DOI to support legislation that would allow it to establish an independent review process, and to amend the proposed regulation to include an independent review process should legislative authority be granted to DOI.	Agree. CDI has no current statutory authority to require that an independent review process of rescissions be established.
Section 2274.80 Amendment: The commissioner shall amend this section, provided legislative authority is granted, to include an independent review process ensuring that insurers are not the final arbiters in determining whether an insured's policy should be rescinded.	If such statutory authority is granted, at that time, CDI can amend these regulations.
Civil Justice Association Kim Stone 07/17/09	
The issue of recession of individual health care policies has been an active area for litigation in recent times. With case law finally beginning to settle the small levels of ambiguity in existing law, we fear that some of the proposed regulations are ambiguous and will lead to additional litigation. Regulations where a degree of subjectivity is required to interpret adherence (or not) will lead to additional lawsuits. This will mean additional costs – dollars that are being spent on lawyers rather than on doctors.	Underwriting standards, such as those set out in Section 2274.74, deal with factual determinations made by underwriters applying the health history information (facts) gathered from various sources, including the self-reported information on the health insurance application. The underwriters then apply the health history information/ facts gathered to the insurer's underwriting guidelines.

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Specifically, some of the underwriting standards proposed in section 2274.74 contain subjective requirements that will lead to litigation to determine whether an insurer has met its obligations when conducting medical underwriting: • 2274.72 (b) imposes a "reasonable layperson standard", which is a new legal standard for which there is yet no statutory or regulatory precedent. This standard invites litigation over interpretation. • 2274.74 (a) (1) and (3) would require insurers to obtain the applicant's personal health record (PHR), "if applicable". This standard would invite questioning – how much pursuit is required before a record is legally not available? • 2274.74 (a) (1) would require insurers to obtain "health history information from external verifiable sources othe than the information provided by te applicant on the health history questionnaire." This open-ended requirement lacks clarity, and an insurer could always be accused of doing inadequate verification. • 2274.74 (a)(2) would require insurers to obtain and evaluate commercially-available medical information about an applicant. What specific information should the insurer evaluate in order to permit the subsequent rescission? Litigation challenging a rescission would question both the sufficiency of information obtained and the adequacy of its evolution. • 2274.74 (a)(3) and (4) would require insurers to check "reasonably available sources" of health history information. The term "reasonably available" invites litigation to define it. • 2274.74 (b)(2), (3), and (4) would require insurers to compare all of the collected health history information and review for information that appears "doubtful or otherwise questionable". This requirement does not give insures sufficient information to comply, raising yet another issue for litigation. • 2274.74 (b) (6) requires insures to "resolve all reasonable questions or omissions," which "may include, but is not limited to, information obtained through (a) the insurer's further communication with the applicant, (b) a review of medical record and other sources of health history of health status information, such as a PHR, for each individual who has applied for insurance coverage or (c) a commercial pharmaceutical or medical information database." This requirement, with "may include but not limited to," again provides an invitation for litigation.	CDI's standards for these highly fact driven determinations must remain flexible to allow for variation among insurers in how they can conduct their underwriting within legal parameters. With flexibility comes some subjectivity, especially when the insurer's underwriters are charged with exercising professional judgment about how to apply their own medical underwriting guidelines to the health history information gathered. Similarly, these regulations provide for flexibility in determining how many sources and which external sources of health history information an insurer must consult in order to meet the regulatory standards of completing medical underwriting and resolving all reasonable questions arising from an application. The regulations provide clarity and certainty regarding standards for avoiding postclaims underwriting while building in the flexibility needed by insurers to meet the standards.

Verbatim Text of Comments	Response
Therefore, the Civil Justice Association urges you to clarify the regulations in order to provide certainty for all parties and in order to reduce the need for litigation.	
Consumer Watchdog (CW) Jerry Flanagan 07/20/09	**CW**
I. Section 2274.74 Standards for Avoiding Prohibited Postclaims Underwriting *Thompson Standard* Subdivision (c) of section 2274.74 appears to allow health insurers to rescind, cancel, limit a policy or certificate, or increase the rate charged if the insurer completes medical underwriting as required by subdivisions (a) and (b). As written, subdivision (c) is inconsistent with California Supreme Court precedent and section 2274.78 of the proposed regulation as described below. Section 2274.74 (c) should be amended to alleviate any confusion over the narrow instances in which rescission of an insurance policy is appropriate. Section 2274.78 of the proposed regulations, addressing Post-Contract Issuance Rescission, correctly states that rescission and cancellation is limited to instances where a health insurer can prove that an applicant omitted or misrepresented material health information when applying for coverage and the health insurer can demonstrate facts were known to the applicant and the applicant appreciated the significance of the information requested. In *Thompson v. Occidental Life Ins. Co.,* 513 P.2d 353 (Cal. 1973), the California Supreme Court sought to protect innocent consumers against reprisals by insurance companies after they file a claim. *Thompson* provides that "if the applicant for insurance had no present knowledge of the facts sought, or failed to appreciate the significance of information related to him, his incorrect or incomplete responses would not constitute grounds for rescission." *Thompson*, 513 P.2d at 360. Section 2274.74 (c) should be amended to reflect the Thompson limitation on rescission. Simply, completing medical underwriting is a necessary, but not sufficient, basis for rescinding coverage. Insurers must also demonstrate that the consumer knew of and understood the significance of the medical information at issue, and understood that the insurer's application sought that information. Further, the *Thompson* bar on rescission should be applied to all cancellations and other post-	**CW §2274.74** Section 2274.74 does not exist in isolation from the standards for post-issuance rescission investigation, 2274.78 (c) where the *Thompson* standard was originally included. Section 2274.74 (c) should be read in conjunction with Section 2274.78. Since the date when CDI proposed these regulations and received these comments, Federal law 111.Pub. L. No 148, Stat. 119 (2010) known as the Patient Protection and Affordable Care Act (hereafter the " Act") was enacted. Section 2712 of the "Act" established a federal standard for all insurers pursuing rescission of a health insurance policy. That standard displaces the *Thompson* standard in California as it is a more stringent standard. The federal standard requires an insurer to prove intentional misrepresentation of a material fact or fraud in an application for health insurance coverage before rescission is legally permitted. Since state regulations are not allowed to interpret, make specific or clarify federal law, no restatement of the applicable federal intent standard is permitted. Nonetheless, the federal standard for rescission applies to all rescissions undertaken by California insurers by operation of law. Federal law (Section 2712 of the "Act") also governs the standards for cancellation and supersedes *Thompson*. Since the *Thompson* case only involved rescission and not cancellation or limitation, CDI declines to apply Thompson to circumstances other than rescission. The statutes which these regulations make specific, implement and clarify do not address any remedy, including equitable remedies, in the event of wrongful rescission. Therefore, CDI does not have the authority to impose equitable remedies for wrongful rescission in these regulations.

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claim policy limitations. Specifically, an insurer may not rescind, cancel, limit a policy or certificate, or increase the rate charged if the patient did not know of, or did not understand the significance of, medical information that the insurer alleges was omitted from the application for coverage. *Common Law Rule Requiring Return to Status Quo* In addition, subsection (c) should be amended to reflect common law limits on the rescission remedy. *Hailey v. California Physicians' Service,* 69 Cal. Rptr. 3d 789, 802 (Ct. App. 2007), construing a Health & Safety Code provision barring postclaims underwriting, also discussed a common law rule applying equally to insurance companies regulated under the Insurance Code: rescission is only permitted where both parties can be restored to the status quo ante, a condition unlikely to be met in the health insurance context.	See response to comment immediately above.
Runyan v. Pacifica Air Industries, Inc. 466 P.2d 682, 691 (1970), in conjunction with previous case law, requires that a rescinded party innocent of fraud be returned to the status quo ante. As articulated in *Spencer v. Deems,* 185 P. 671 (Cal. Ct. App. 1919), the "general rule" is that a court of equity will not "decree a rescission of an executed contract unless the party desirous of effecting rescission is able to place the defendant in status quo . . . ." For a health insurance consumer this requirement means that any consumer, who could have purchased or accessed health coverage from another source prior to enrolling in the individual coverage that was ultimately rescinded, can only be rescinded if the individual has a similar opportunity following the policy rescission. Since a health plan rescission occurs following a major illness, rescinded patients will find it difficult, and likely impossible, to ever obtain new coverage. For these patients, status quo ante cannot be achieved. Therefore, the regulation should make clear that depending on individual circumstances, rescission may not be an appropriate remedy for a health insurer. There are many instances in which individuals cannot achieve new coverage following a rescission. For example, patients who prior to the rescission had the option of obtaining coverage from an employer likely no longer have that option following the rescission. Simply put, many of those who have suffered major debilitating illnesses that require long treatment and recovery, or	This comment does not specifically address the proposed regulation.

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produce permanent disabilities, may not be able to immediately return to work, if at all. Similarly, those whose permanent disabilities bar them from seeking employment will likely never be able to purchase health coverage on their own. This is because the serious and expensive-to-treat illness that precipitated the postclaims investigation and subsequent rescission will almost certainly run afoul of another insurer's underwriting guidelines, and therefore prohibit rescinded patients from attaining new coverage in the individual market. Additionally, many insurers refuse to sell coverage to those individuals who have been rescinded in the past. *Affirmative Requirement for Insurers to Review Records of Previous Members* A new subdivision is needed to provide an affirmative requirement for a health insurer to check its own databases of previous members, including members received in a merger with, or acquisition of, another insurer, as part of the underwriting process. Specifically, health insurers should not be allowed to avoid postclaims underwriting if the member's medical condition was diagnosed while enrolled in previous coverage with the insurer. Without such a clarification, an individual may be rescinded for failing to disclose a condition that the individual reasonably believed the insurer was already aware of.	**Section 2274.74(a)(3)** offers this option to insurers as a valuable source of health history information but does not mandate its use. CDI chose to require at least one source of such information other than the self-reported information on the health history application and this source certainly could include a search of an insurer and its affiliates' own claims databases. However, CDI has chosen not to mandate this particular source but instead has chosen to make it one of several possible sources.
Per the attached news clips, the Robison family's coverage was rescinded after Mark Robison's son, Tylor, underwent a corrective surgery for a congenital defect. The condition had been previously diagnosed while the family was enrolled in an individual Blue Cross Life & Health policy. Following a brief break in coverage, the Robinsons re-enrolled in an individual Blue Cross policy and were later rescinded after Tylor sought treatment for the condition. When Mark Robison re-enrolled in coverage he did not know that Tylor's condition needed be disclosed since the family doctor had previously told him that no medical attention was necessary. In addition, Mark believed Blue Cross already knew of the condition since it had been diagnosed by an in-network physician while the Robisons were enrolled in a Blue Cross policy. It was only after the Robisons re-enrolled in Blue Cross coverage that a physician decided that medical care was needed. Blue Cross cited the Robisons' failure to disclose the condition on the re-enrollment application as the basis for the rescission.	**Agree in part**. See amended text Section 2274.74(a) which requires insurers to obtain health history information from at least one source other than self-reported health history information. One such source could be the insurers own claims database of former insureds.

Verbatim Text of Comments	Response
Reasonable Layperson Standard Should Apply to Medical Underwriting Subsection (a)(4) states that to avoid prohibited postclaims underwriting a health insurer must check: [R]easonably available health history information obtained from all sources for accuracy, completeness and consistency, taking into account that self-reported health information must be evaluated in light of the applicant's status as a layperson not schooled in medicine unless the insurer has documentable grounds to believe the applicant has formal medical training; While Consumer Watchdog welcomes the "reasonable layperson" approach to evaluating an applicant's completion of an enrollment application, the same standard should be applied to those who are not familiar with the particular insurer's underwriting guidelines. Medical knowledge does not provide an individual with knowledge of what information a health insurer deems material to its underwriting guidelines.	Agree. This subsection (a)(4) requires the insurer to review and evaluate self-reported health information using the reasonable layperson standard. CDI believes that these regulations require that this evaluation and standard extends to the insurer's consideration of the applicant's appreciation of questions and responses materiality.
II. Section 2274.78 Post-Contract Issuance Rescission or Cancellation Investigations *Apply to Additional Post-Contract Investigations* Strong anecdotal reporting suggests that post-contract investigations are initiated not just to rescind or cancel a policy after a claim is filed, but more commonly to raise rates charged on the policy, and possibly to reduce benefits or otherwise limit the policy. Subsection (a) and (b) should be amended to apply to claims investigations intended to produce facts or other information that could be used as the basis for an evaluation by the insurer of whether to rescind, cancel, limit a policy or certificate, or increase a rate charged.	Disagree. CDI has chosen to impose the most specific notice and and timeframe requirements on claims investigations which lead to rescission or cancellations. While it is true that post-contract issuance investigations are conducted by insurers and that these investigations may produce a rate increase or limitation of benefits, the insurer is continuing coverage and the insured can inquire of their insurer as to the bases for the insurer's actions. Insureds can file a complaint with CDI if they believe that the rate increase is unjustified or inexplicable
Require Investigation to Commence Within Three Calendar Days Subsection (c) currently allows a health insurer to begin its investigation up to fifteen days after receiving additional medical or health history information. This unnecessarily long period of time allows companies to take a wait-and-see approach and possibly delay investigations until further claims for coverage are filed. Since insurers often request additional medical or health history information when a diagnosis of a suspected pre-existing condition is made, there is no reason for the long delay suggested by the proposed regulation. As such, investigations should be commenced within three calendar days of receipt of the information.	Disagree. Up to 15 days is a reasonable timeframe for an insurer to review what could be a substantial amount of new information before determining whether or not to open a rescission investigation. The insurer must also consider their degree of compliance with the completion of medical underwriting before initiating a rescission investigation. CDI prefers to give the insurers ample time to make a careful decision regarding the launching of a rescission investigation.

Verbatim Text of Comments	Response
Limit the Period of Investigation to 30 Days Subsection (g) currently allows insurers to continue such investigations for up to ninety days after giving notice of the investigation to the insured. Such an excessive period of time will cause unnecessary worry to the patient or family member already under the stress of illness or injury. The period of the investigation should be limited to thirty days.	Disagree. Rescission investigations can involve gathering substantial documentation and a careful and complete review may often take longer than 30 days. CDI prefers that insurers conduct a careful and complete investigation rather than rush to judgment. Further insurers must often rely on others to provide needed documents.
Allow Individuals to Participate in the Insurer Investigation A new subsection should be added to allow an individual to participate in the health insurer's investigation by clarifying why the new medical or health information received by the insurer was not disclosed as part of the original application for coverage. The individual should be given the opportunity to communicate to the health insurer whether the medical or health information at issue was known to the individual at the time the application for coverage was completed and whether the individual appreciated the significance of the information, or whether the individual understood what information was requested by the application.	Individuals can participate in the rescission investigation and the proposed regulations anticipate their participation. Their participation will be triggered once the required notices are given by the insurer. The regulations also require insurers to provide copies of all documents under review in the investigation to the insured. This requirement will also prompt insureds to participate if they choose.
Require Insurers to Make Specific Inquiries A new subsection should be added to detail the specific types of questions the insurer should explore during its post-contract investigations in order to establish whether the medical or health information was known to the individual at the time the application for coverage was completed and whether the individual appreciated the significance of the information requested by the application. Such considerations should include: • Did the insured recall some matter but not appreciate the significance of it? • Did the insured not understand what information was material to the plan's underwriting? • Did the insured not disclose a hospital visit because a test came back negative and the application question requested only information about known "health conditions"? • Did the insured not disclose certain information because he or she did not understand it to represent a medical condition material to the insurer's underwriting guidelines? • Did the insured's disclosure of a general health problem explain any failure to disclose additional details pertaining to it?	The Department appreciates the suggested questions but declines to adopt such detailed mandated questions. Insurers should be allowed to tailor the questions they ask in a post-issuance rescission investigation to the specific requirements of the case. However, such rescission investigations are subject to examination by the Commissioner.

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• . Did the insured simply forget, and therefore not have knowledge of, a health condition or symptom he or she once had? • . Did the insured not understand the application question? • . Did the insured not disclose a condition because the insured had been previously enrolled by the health insurer under a different contract and assumed the insurer's knowledge of medical diagnosis and treatments provided during the previous coverage period? • . Did the insured believe some matter pertained to a minor ailment, not a serious illness? In addition, the subsection should be clarified to indicate that the insurer's post-contract investigations should be conducted under the same reasonable layperson" standard that applies to an insurer's interpretation of application responses under Section 2274.73.	
Allow Individuals To Request Department Assistance Before Investigation is Completed Subsection (i) currently allows insurers to rescind coverage before the individual has an opportunity to appeal the rescission to the Department of Insurance. Given the great threat to patient health and finances once coverage is rescinded, and the huge disparity in resources and expertise between insurers and individual consumers, a process must be provided for individuals to request assistance from the Department as soon as the insurer provides notice of its investigation. Such participation by the Department is essential to ensure that the individual has a fair opportunity to participate in the insurer's investigation. The patient's inability to reach insurer staff overseeing a post-contract investigation, inability to understand the allegations made by the insurer in its notice of investigation, and inability to understand complex medical information all pose potential threats to a patient's ability to participate in the insurer's post-contract investigation, for which assistance from the Department will be necessary.	This is allowed by current statute and the regulations. Nothing in these regulations bars an insured from seeking Department assistance the moment they become aware of a rescission investigation.
IV. Section 2274.73 Standards for Health History Questions Section 2274.73 sets out reasonable standards for health history questions, requiring plans to obtain information from sources other than the applicant, limit questions to those reasonable and necessary for medical underwriting and essential for calculation of prospective risk, and phrase questions to elicit information known to the applicant. However, several changes are necessary.	**IV.** There is nothing in the regulations that allows review of a PHR as sufficient to avoid postclaims underwriting. The standard for obtaining and using non self-reported information is at least one source, but if there are conflicts in the information that is self-reported and the information obtained from the outside source, additional underwriting is required by the regulations.
Reviewing a PHR Should Not be Sufficient to Avoid Postclaims Underwriting	

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Subsection (a) provides that, "[w]henever possible, information from a [patient health record ("PHR")] shall be requested and, if available, relied upon during medical underwriting in addition to or, if sufficient, instead of health history questionnaires." This subsection must be amended to clarify that reviewing the PHR is not sufficient to avoid prohibited Postclaims underwriting. PHRs are not medical records and may not provide a complete view of a patient's health history.	
Limit the Period of Application Questions Individuals applying for coverage cannot be reasonably expected to remember health events for a period of longer than ten years. Specifically, subsection (d)(2) should be amended to read: "Specified time periods for each question shall be as short as possible to make a reasonable underwriting determination and must be limited to time periods required by sound actuarial underwriting standards used by the insurer but under no circumstances shall exceed ten years." Similarly, subsection (e)(2) should also be amended to limit questions to health events over the last ten years. If underwriting guidelines require additional information, insurers should pursue alternative methods of obtaining information, such as medical records.	Agree. Look-back periods are limited by the regulations. The exact look-back period is scrutinized by CDI attorneys reviewing the questions and these regulations will provide guidance by requiring the shortest possible look-back period allowed by actuarial priniciples. Some flexibility is needed here to allow different look-back periods for different conditions and diseases.
Limit Application Response to Yes, No, or Not Sure Clarity and simplicity should be the goal of the health history questionnaires. Subsection (d)(4) must be amended to require health history questions to only offer response choices of Yes, No, or Not Sure. As written, this subsection appears to allow the Department to approve applications with other response types, which could undermine the clarity of the applications and result in response errors by applicants. In addition, the subsection should clarify that an answer of "Not Sure" constitutes an inadequate, unclear, incomplete, doubtful or otherwise questionable response on the application requiring reasonable and appropriate follow-up by the health insurer prior to issuing a policy.	Agree. The Department has amended the text- see Section 2274.73(d)(4) to require all insurers to include all three response options for health history questions.
R*equire Separate Health History Questionnaires for Each Applicant* Subsection (f) should be amended to require insurers to provide a separate health history questionnaire for each individual applicant. Single questionnaires that allow for separate responses from multiple applicants will not be easily comprehensible to laypeople.	Agree. The regulations achieve this objective. See Section 2274.73(f).

Verbatim Text of Comments	Response
V. Section 2274.77 Return of Completed Application for Health Insurance Coverage at Time of Policy Transmission Subsection (b) currently requires applicants "immediately to contact the insurer if there are any discrepancies on the application compared with the information submitted by the applicant." This requirement should give the individual seven calendar days to review the application and report discrepancies.	**V. Immediately could be interpreted as seven calendar days. This provision will be subject to CDI attorney review as it is part of the health insurance application.**
Council for Affordable Health Ins. (CAHI) J. Wieske 07/18/09	**CAHI**
	CAHI §2274.72 These regulations place the decision to share a PHR with the applicant. It is fully within an applicant's right under HIPAA to make their PHR available to insurer as part of the insurer's consideration of the health insurance application. Agree with the commenter that the benefit of a PHR is that its source information is claims information which is potentially useful from an underwriting standpoint.
	CAHI §2274.73 See amended text at Section 2274.73(a) which addresses this comment. This change in the text makes use of the PHR one option available to insurers in addition to self-reported information.
	CAHI §2274.73(d)(4) The purpose of requiring the response choice of "Not Sure" in addition to Yes or No is precisely to permit the applicant a full opportunity to answer accurately and truthfully. The Department agrees that applicants have an obligation to complete

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	their insurance application to the best of their ability and to give complete responses. By requiring the Not Sure response option, the applicant will better be able to meet this obligation and the insurer will gain additional insight into the health history areas where further underwriting might be warranted. The Department has had recent experience with the Not Sure response option and learned that insurers can in fact use this option to more efficiently underwrite an application. The statute requires questions to be clear and unambiguous. Response options are part of the question. In order to make the question clear and unambiguous, a Not Sure response option must be provided. If the applicant truly cannot answer Yes or No and the truthful answer is Not Sure, the applicant is unable to accurately respond unless the Not Sure response option is available. **CAHI §2274.73(d)(5)** Subsection 2274.73(d) recognizes the reality that many applicants will have difficulty recalling or remembering the health history information being requested. CDI believes it's best for insurers to be informed in these circumstances so the insurer can seek additional information, if necessary, from other more objective sources. Insurers also utilize structured recorded phone interviews conducted by trained personnel to question the applicant when they don't recall or remember required information. CDI has already approved an application for one insurer that meets the requirements of these regulations thereby confirming that it is not unwieldy.

Verbatim Text of Comments	Response
	CAHI §2274.74 Disagree. This section does not require an insurer to gather medical records for every applicant. To clarify, see amended text of Section 2274.74(a) which states that at least one source of objective health history information other than self-reported information is required. Use of additional sources is determined by the insurer and will depend on the health insurance application to be underwritten. Agree that medical records are useful if the applicant is unclear about their medical history. These regulations allow precisely such use by an insurer allowing the insurer to determine if and when medical records are needed to obtain the detail the insurer requires to meet the terms of its own medical underwriting guidelines. Applicants are required by health insurers to agree to allow the insurer to access the applicant's protected health information (PHI) under HIPAA. Such authorization is well within HIPAA and is routinely obtained. There is no evidence that more robust pre-issuance underwriting will lead to increased costs to insurers. Insurers can make more efficient use of outside sources of information. Insurers will be using easier to understand health history questionnaires which should yield more reliable self-reported information. Agree that the CDI lacks authority to impose an external review process on insurers at this time.

Verbatim Text of Comments	Response
	CAHI §2274.78 Disagree. The cost of undertaking extensive postclaims rescission investigations will be reduced. The cost of adjusting claims multiple times in the case of executed rescissions will be reduced. Administrative and legal costs associated with rescissions will be reduced. Underwriting will be more efficient as a result of the need to conduct more robust pre-issuance underwriting. Disagree. CDI believes the timeframes are fair to insurers and fair to consumers whose health insurance coverage is at risk. A timely resolution of a rescission investigation is in the best interest of both parties to the insurance contract as well as health care providers. Insured persons currently have a right to request their own medical records. The HIPAA authorization that insurers routinely obtain from applicants gives the insurer the right to share any and all health history information, including medical records, with the applicant/ insured.
Health Access (HA) Anthony Wright 07/20/09 Health Access is generally supportive of the proposed regulations. We support the requirement that medical underwriting be completed prior to issuance of coverage. We also support a plain requirement that failure to complete medical underwriting should preclude rescission. We were astonished to learn that insurers did minimal if any medical underwriting in advance of issuing coverage but instead relied on post-claims underwriting to determine whether an individual is insurable. This is just plain wrong given the consequences of rescission. With respect to the cost impact on private persons or businesses, we take note that many individuals who are self-employed rely on individual insurance to allow them to create a business. Inappropriate and improper rescissions of individual health coverage undermine the economy by	**HA** General comments supportive of proposed regulations; do not require a Response.

Verbatim Text of Comments	Response
creating uncertainty as to whether coverage will be available. We offer comments intended to improve clarity and to strengthen some of the provisions of the proposed regulations. 1. Lack of Clarity: Failure to complete medical underwriting by the insurer should preclude rescission: S.2274.4 (c) to assure that rescission may only occur consistent with proposed S.2274.78: S.2274.4 (c) as currently drafted prohibits rescission on receipt of a claim only if the insurer has completed all of the requirements of S.2274.4 (a) and (b). This means that if an insurer can demonstrate that the insurer failed to take any step specified in terms of medical underwriting, then the insurer can rescind the policy. This creates an incentive for insurers to fail to conduct complete medical underwriting. It is also contrary to the stated intent in the statement of reasons: "However, if an insurer has not completed medical underwriting, as defined, prior to policy issuance, the regulations will prohibit the insurer from subsequently cancelling, rescinding or limiting the policy in question."	This section has been amended to address this issue. The amendments require insurers to engage in the specific activities enumerated to assure that it has the information needed to complete medical underwriting. If seeking to rescind a policy, the insurer must have first completed the required medical underwriting. Therefore, unless the insurer has complied with this section, it has not completed medical underwriting and therefore rescission is not permitted. The amended text of Section 2274.74(a) clarifies that it is the insurer's medical underwriting guidelines that generally govern the level of detailed health history information that is needed to complete underwriting. Medical underwriting guidelines tend to be very detailed and if the information required was attainable but not sought, insurers will not have completed medical underwriting and will be barred from rescinding.
2. Lack of clarity: Insurers should be required to review their own records with respect to individuals who were previously insured by the insurer. The standards for medical underwriting require review of medical records but not necessarily that the claims experience or other information that the insurer may have on an individual previously covered by that insurer.	These regulations only require insurers to obtain medical records to the degree necessary to obtain the detailed information required by their medical underwriting guidelines and if there's remaining questions from the application that require resolution. The text never required insurers to access medical records unless more detailed information was needed about the applicant based on either internal contradictions on the application or conflicts between self-reported health history information and health history information obtained from an outside source such as pharmaceutical data.
3. Lack of clarity: Applications for coverage should not be permitted to include multiple individuals: instead, the health history of each individual should be provided separately. If an application for coverage encompasses more than one individual and if medical underwriting applies to each individual, then the health history of each individual should be separate. There have been specific instances in which consumers failed to comprehend that a health history encompassed more than one individual.	The regulations require a separate health history for each applicant. See Section 2274. 73(f).
4. Lack of clarity and stronger consumer protections: Individuals should be permitted to provide additional information during the rescission process. Individuals are not clinicians or actuaries and may not appreciate the significance of the information provided. Someone may accurately respond	There is nothing in the regulations which bars individuals from providing additional information during the rescission process. In fact, the entire purpose of the notice

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within the limits of their knowledge. The reasonable layperson standard is helpful here but permitting consumers to provide additional information during the rescission process is also appropriate.	requirement in Section 2274.78 (e) is to give the insured an opportunity to offer such additional information.
5. Stronger consumer protection: Consumers should given notice that the insurer will check medical history and claims record as part of the process of determining whether to insure the consumer. This notice should be included in the questionnaire to be completed by the individual consumer.	The Department chose not to require this level of detail in the notice required to be provided in Section 2274.78(e).
6. Inconsistent with statutory authority: S. 2274.76 should be amended to be consistent with Insurance Code S. 10119.3 which requires that "A health insurance application shall include a declaration advising declarants' of the civil penalty authorized under this section.", that is, a civil penalty of up to $10,000 if an agent willfully states any material facts that he or she knows to be false. The regulation should plainly include a declaration that if the agent willfully states a material fact that he or she knows to be false, the agent faces a civil penalty of up to $10,000.	It is not necessary to include a specific reference to the civil penalty included in Insurance Code section 10119.3(c) and (d) because this section is referenced in the regulations and because the statute already expressly requires this statement in the attestation. A regulation requiring this would duplicate the exact requirements of the statute.
Kaiser Permanente Ins. Co. (KPIC) Conrad Llaguno 07/21/09	**KPIC**
Section 2274.73(d)(4) and (d)(5) The above proposed revision (addition of "*Not sure*" response to *Yes or No* responses) can provide for responses that are ambiguous and not understandable, It also can encourage applicants to submit an incomplete application. If an individual does not understand a question, he or she may call the health plan, broker, or their physician for guidance. If they understand the question, but do not know the answer, they should make an effort to learn the answer prior to submission. Applicants must be subject to some obligation to make reasonable efforts to determine and gather the information requested in order to submit as complete an application as they are reasonably able. In no event should an applicant sign and submit (or permit submission of) an application he or she does not understand or is unable to complete. The standard should be for the insurer to verify the completeness and accuracy of the information submitted on the application and, if in reviewing the application, it is clear to the insurer that the applicant's responses are incomplete, to immediately follow-up with the applicant to complete the application. However, the application	**KPIC §2274.73(d)(4) and (d)(5)** The purpose of requiring the response choice of " Not Sure" in addition to Yes or No is precisely to permit the applicant a full opportunity to answer accurately and truthfully. The Department agrees that applicants have an obligation to complete their insurance application to the best of their ability and to give complete responses. By requiring the Not Sure response option, the applicant will better be able to meet this obligation and the insurer will gain additional insight into the health history areas where further underwriting might be warranted. The Department has had recent experience with the Not Sure response option and learned that insurers can in fact use this option to more efficiently underwrite an application. The statute requires questions to be clear and unambiguous. Response options are part of the question. In order to make the question clear and unambiguous, a Not Sure response option must be provided. If the applicant truly cannot answer Yes or

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form itself should support that obligation, not undermine it. We believe that adoption of subparts (4) and (5) above would undermine the application review and enrollment process as it would permit and perhaps encourage applicants to submit incomplete applications. Additionally, because an insurer may not rely on an ambiguous answer, such as “not sure”, the proposed format will result in an applicant having to experience significant delays in medical underwriting review and enrollment and/or the health plan issuing more denials. Thus, adoption of this regulation would adversely impact the individuals whom this regulation is intended to benefit.	No and the truthful answer is Not Sure, the applicant is unable to accurately respond unless the Not Sure response option is available. There is nothing in the regulations that prevents insurers from rejecting incomplete applications. However, when an applicant checks the box “ Not Sure” that is not an incomplete application. This response signals an area for follow up by the insurer thus increasing underwriting efficiency since the insurer is more quickly notified of areas requiring its attention.
Section 2274.74(a)(2) The legal underwriting standard is to resolve all reasonable questions arising from written information submitted on or with an application prior to issuing a policy. (See below for comment on proposed section 2274.74(b)). It is unnecessary to impose this requirement to ensure an effective medical underwriting process because it may not be necessary in every case for an insurer to investigate an applicant's medical history/status in this manner. If there are no indications from the profile of the applicant (i.e., age and other responses do not reasonably indicate that further investigation is necessary), or the insurer has otherwise made reasonable efforts to ensure the accuracy and completeness of the information submitted on the application, the requirement to obtain and evaluate the information described is unnecessary. KPIC notes the wording of proposed section 2274.74(b)(3) of "reasonable and appropriate follow-up". This language is consistent with the legal requirements all insuring plans must already follow. However, the proposed language in section 2274(a)(2) would place a greater burden on plans by requiring a more extensive investigation in every case, ultimately leading to greater administrative costs in processing applications. Such costs would hamper the industry’s ability to achieve the common goal of health insurance “affordability”. Additionally, KPIC believes that proposed regulations purporting to impose specific underwriting criteria that in effect require insurers to thoroughly investigate every application against commercially available prescription drug or claims databases in order to demonstrate that underwriting is "complete" are defective. Such regulatory requirements exceed the authority granted by relevant enabling legislation. The relevant enabling legislation would appear to be section 10113.95, which simply requires insurers to: "... have written policies, procedures, or underwriting guidelines establishing the criteria and	**KPIC §2274.74(a)(2)** The statutory authority cited for this Section is not Section 10113.95 as noted by the commenter; it is the cases and statutes cited in the Note under Authority. Section 10113.95 does not limit the authority of the Commissioner to clarify and make specific the standards for avoiding prohibited postclaims underwriting. CIC Setion 10113.95 does not limit the Commissioner’s authority to issue underwriting standards to avoid prohibited postclaims underwriting. See changes to Section 2274.(a) and (a)(2). This section of the text has been amended to further clarify that the minimum requirement of an insurer to obtain health history information other than self-reported health history information provided by the applicant is to consult at leaste one outside source, such as commercially available pharmacy or claims data or the insurer’s own claims database and underwrite such information but only if athese sources have available information about the applicant. This section of the text has been amended to further clarify that the degree to which an insurer must engage in any of the specified underwriting activities listed in (a)(1)-(7) is determined by the clear standard of complete and consistent application of the insurer’s medical underwriting guidelines and rating plan. This section does not specify underwriting criteria; only the types of underwriting

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process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the insurer rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions." Because the proposed regulatory section exceeds the scope and authority found in the enabling statute, KPIC the Plan recommends removing this section.	activities that may be undertaken by the insurer in order to meet the standard set in (a). This section does not require the insurer to pursue an extensive investigation of every application; in fact it requires the insurer to complete medical underwriting by engaging in whatever underwriting activities are necessary to apply the insurer's medical underwriting guidelines in a complete and consistent fashion.
Section 2274.78(c) Fifteen calendar days is insufficient for insurers and HMOs the Plan to determine if there is truly a rescission- investigation trigger identified. Particularly for KFHP, with its integrated model of health care delivery, such issues are not usually identified through the claims process. KFHP requests a 60-day window for initial review of such information. Although we appreciate the DOI moving away from the term "willful misrepresentation", as had been used in past, there is little direction provided as to how a plan would "ascertain" that an applicant appreciated the significance of the information requested.	**KPIC §2274.78(c)** The Department of Insurance regulates insurers, not HMO plans. The requirement in this Section is that an insurer commences a review or investigation of a possible rescission within 15 days of receiving medical or health history information arises if the insurer has either received a claim or a notice of a claim as defined in 2274.78(a). The 15 day requirement is not the time limit for reviewing the information as stated in the comment; it is the timeframe within which the insurer must commence the review or investigation. The Department of Insurance has never used the term "willful misrepresentation" in the past in any context. That term is not part of the Insurance Code section prohibiting postclaims underwriting and as such is not applicable to insurers. The text of the regulation has been amended to delete the requirement that the insurer ascertain that the applicant appreciated the significance of the information requested because this requirement has been supplanted by new federal law enacted on March 23, 2010, the Patient Protection and Affordable Care Act of 2010. Section 2712 of that Act established the requirement that the insurer may only rescind health insurance upon proof of intentional misrepresentation of a material fact or fraud.
The Department's Initial Statement of Reasons mentions the "Reasonable Layperson Standard", yet it is not clearly referenced in the proposed text of the regulation. Using language similar to the prudent layperson definition of an emergency under the Knox Keene laws will lead to less	The Reasonable Layperson Standard is defined in Section 2274.72(b). This definition is consistent with the prudent layperson standard found in federal law and other State laws such as the Health and Safety Code. The Department views the

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confusion when trying to resolve rescission issues.	reasonable layperson standard in this context (underwriting reviewing self-reported health history information provided by a layperson) as virtually identical to the prudent layperson standard used by HMO plans to evaluate whether an enrollee's use of emergency services was reasonable.
2274.78(d) and (e) A true investigation could include obtaining outside medical records, retrieval of other off-site documents, and multiple other time consuming steps. To gather and evaluate this information in seven days, and provide a complete set to the insured would risk notices to people who really are not subject to rescission, or a lost opportunity to use information gathered after the seven days have passed. The proposed language would result in enrollees being unnecessarily alarmed that their coverage was at risk. Due to California's regulatory scheme, it is preferable to have one set of timelines for this process for all regulators. We ask that the Department collaborate with the DMHC on the timeframes and requirements for rescission review and investigation.	**KPIC §2274.78(d) and (e)** This Section does not require that the insurer complete gathering and evaluating the referenced information within 7 days. This Section requires that the insured receive notice of the insurer's decision to commence a rescission investigation within 7 days of its actual commencement. This Section requires the insurer to provide only whatever information it possesses at the time of the notice. Any information that an insurer has not yet obtained, such as medical records, is not required to be sent with the 7 day notice of commencement of the investigation. The Department of Insurance works collaboratively with the DMHC when possible, however each Department has obligations under its respective statutes which it must meet. DMHC has abandoned its original rulemaking effort regarding rescissions. DMHC was invited to comment on these regulations.
Section 2274.78(h) Allowing the insured to go to the DOI prior to going through KPIC's appeal process is not consistent with other dispute processes. For instance, most denial letters include language requiring the insured to work with their insurer in order to attempt resolution, prior to seeking the involvement of the regulator. Having the insured first contact their insurer gives the insured an opportunity to have the issue(s) reviewed by a larger health insurer audience, which is not necessarily limited to the department that made the initial decision. This process not only serves the insured well, but allows for a plan to assemble the documents the DOI will request as part of their investigation (if that step is, in fact, required).Additionally, if an insured were in a situation where time is a factor (where they are about to obtain/require health care services), we recommend the option of having these types of appeals go through the health insurer's expedited review process. We recommend that the DOI collaborate with the DMHC on this issue, as significant industry effort has been directed to this matter.	Current law allows an insured to proceed directly to the Department of Insurance with a request for assistance about any dispute involving insurance coverage regardless of the issue. There is no statutory requirement currently requiring an insured to file an appeal with the insurer before seeking Department assistance. Insureds are currently entitled to seek Department assistance if their coverage is rescinded. Section 2274.78(h) implements and makes specific current law allowing insureds to seek Department review of any insurance coverage complaints. CDI lacks statutory authority to require an insured to use an insurer internal appeals process prior to seeking assistance from the Department.
2274.76 – KPIC's comment regarding this section must refer to the previous proposed Section 2274.75 -	**KPIC §2274.76** Section 2274.75 addresses the kinds of documentation that an insurer must retain to

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Documentation Requirements and Examination by Commissioner. That section attempts to clarify what it means to document "completion of medical underwriting." Included in this section is the requirement that the insurer document "all communications with the assisting agent regarding the application, the submission of the application and supplemental information, or the underwriting of the policy based on application information." Proposed section 2274.76 apparently attempts to elaborate on this documentation requirement, although its phraseology and meaning is unclear. Regarding the regulation's requirement to document communications with agents in order to demonstrate "completion" of medical underwriting, the proposed regulation goes beyond the requirement in Ins. Code §10119.3, which provides as follows: (10119.3 verbatim quote omitted)	satisfy the Department's examination needs. If an insurer relied on communications with an assisting agent as part of the insurer's underwriting, such communications must be documented and retained for examination purposes. This requirement is imposed because it allows the insurer to demonstrate how its communications with the assisting agent contributed to completing medical underwriting. The authority for section 2274.75 is Insurance Code section 10384 not 10119.3.
Any communication an insurer may have with an attesting broker or agent should be limited only to whether or not the attestation was made, if not clear on the face of the application. If the agent/broker did so attest, then the insurer may rely on such attestation, there is no need to go further. As to whether the actual disclosures of health history on the application are accurate and complete, that is an inquiry that the insurer may have directly with the applicant pursuant to the insurer's underwriting process. The Department should be aware that an insurer cannot address specifics concerning the applicant's health history that may have been disclosed by the applicant to the agent or broker in the course of the agent/broker's assistance in "submitting the application." To do so would raise HIPAA privacy issues because it would be unclear to what extent the Code section 10119.3 already require the documentation of an assisting broker's attestation during the application submission process, proposed section 2274.76 is redundant and raises HIPAA privacy issues KPIC recommends that the entire section be removed.	Section 2274.76 interprets and makes specific Insurance Code section 10119.3. This section does not require the disclosure of any health history information supplied by the applicant to the assisting agent. This section does require the insurer to insist on an agent attestation if an agent is involved in order for the insurer to complete medical underwriting. See the last sentence of Section 2274.76(e). There are no HIPAA privacy issues presented by this Section because assisting agents are not required by this regulation to disclose health history information to the insurer. Further, agents are appointed by insurers to sell their insurance products and part of the appointment contract makes agents HIPAA business associates. Business associates are allowed by HIPAA to share protected health information subject to a variety of federal requirements. Disagree. This section is needed to implement the newly enacted Ins. Code Section 10119.3. Agents are a key part of the application submission process and the new requirement that they attest to their assistance is squarely aimed at bringing them into the underwriting process conducted by the insurer, if necessary.
2274.77 Given the adoption of web-based application submission, KPIC asks for clarification that electronic forms of documents will meet the regulatory requirements set forth in this section.	**KPIC §2274.77** Such electronic communications are governed by Civil Code Section 1633.2(g) and are therefore subject to these regulations to the extent such electronic

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	communications are in lieu of any non-electronic communications or documents used by the insurer.
Assoc. of Ca. Life & Health Ins. Co. (ACLHIC) Anne Eowan 05/02/10	**ACLHIC**
Before we provide comments on the revised text, we note that it does take into consideration some concerns expressed in our original comment letter dated July 20, 2009 regarding Personal Health Records (Section 2274.72 (d)) and clarifications as to underwriting standards (Section 2274.74 (a) and (c)). However, the bulk of our concerns remain unaddressed, and we note that the revisions do not cure the extensive legal issues raised in our original letter that are still relevant to the revised text. We are appending our original letter, and would highlight our comments that request revisions that would: (1) Carve out policies offered in the group market; (2) Carve out non-comprehensive policies in the individual market; (3) Limit subjective interpretation in the regulation; (4) Allow for an electronic means of attaching or endorsing an application; (5) Accurately reflect latest case law (detail provided later in this letter); and (6) Extend the date of implementation. We would respectfully ask for your reconsideration of the issues raised by our previous letter. With regard to the revised text, we would like to provide the following comments on a section by section basis:	NO RESPONSE NEEDED. General comments on amended text Please see responses to comments from this commenter to original text.
Section 2274.75 Documentation Requirements and Examination by Commissioner Consistent with the revisions made in Section 2274.74 (c), the requirements of this section should not be applicable if an insurer decides not to rescind, cancel or limit a policy or certificate based on the health history or health status of the insured. The standards of Section 2274.75 relate to completing all medical underwriting and resolving all reasonable questions arising from information submitted by the applicant. If an insurer did not take one of these actions, the insurer would assume the underwriting risk for any omissions or	**Section 2274.75 Documentation Requirements and Examination by Commissioner** This section of the regulation establishes documentation requirements that are subject to examination by the Department. In the event that an insurer decides not to rescind, cancel or limit a policy, that decision can be documented as an underwriting decision under this Section's requirements. In that circumstance, the amended text of Section 2274.74(c) which removes the duty on the insurer to comply with the underwriting standards of Section 2274.74 (a) and (b) will also dictate the insurer's

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ambiguity resulting from incomplete medical underwriting or unresolved questions. Thus, we see no reason for this section being applicable to insurers in that instance. ACLHIC recommends the addition of the following language as a new subdivision (a) (7): "However, in the event the insurer undertakes never to rescind, cancel or limit a policy or certificate based on the health history or health status of the insured, Subdivision (a) of this Section 2274.75 imposes no duty on the insurer to complete medical underwriting and resolve all reasonable questions."			documentation of this decision. Section 2274.75 (a) (4) requires documentation of all communications relating to the processes described in this Article. In the circumstance where an insurer chooses not to rescind and therefore not to underwrite, this Section requires documentation of such a communication in the applicant's file. If there were no rescission to exam, there would perforce be no such documentation. The suggested language by the commenter is substantively reflected in the amended text in Section 2274.74 (c).
Blue Shield Life & Health Ins. Co. (BSL&H)	**Andrea DeBerry**	**05/04/10**	**BSL&H**

SUMMARY AND RESPONSE TO PUBLIC COMMENTS
California Department of Insurance
CCR Title 10, Chapter 5, Subchapter 2
Article 11

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Preliminarily, Blue Shield Life notes that the revised text reflects a response to only a few of the detailed comments submitted on July 20, 2009 in response to the original proposed regulations by Blue Shield Life and by the Association of California Life & Health Insurance Companies ("ACLHIC"). With minimal exceptions, the revised text does not cure or even address the numerous legal issues identified in the prior comments. Blue Shield Life urges the Commissioner to reconsider those comments and to correct those provisions that exceed the Department's authority pursuant to California law as specifically addressed in those letters.	This general comment does not address proposed text. The Department has amended the text as necessary and has ample authority to promulgate these regulations.
In addition, the legal landscape relevant to these regulations has changed significantly since the Department released its proposed regulations, and it is necessary for the Department to consider these clarifications to the law to ensure its regulations are authorized and consistent. On January 19, 2010, California's Second District of Court of Appeal issued its published decision in *Nieto v. Blue Shield of California Life & Health Insurance Company*, 181 Cal. App. 4th 60 (2010), *rev. denied* (April 28, 2010). *Nieto* is the first decision to directly address the requirements of three of the Insurance Code provisions that are relevant to the proposed regulations: Insurance Code Sections 10384, 10113, and 10381.5. The proposed regulations are at odds with the holdings of the *Nieto* court with respect to the interpretations of these statutes, which affect the underwriting requirements and rescission rights of California health insurers. As such, Blue Shield Life requests that the Commissioner re-review the proposed regulations in light of the *Nieto* decision, and revise the regulations so as to achieve consistency between the published judicial law of this state and the regulations by which insurers must abide.	Please refer to extensive discussion of the *Nieto* case in the Update of Information Contained in the Initial Statement of Reasons
Proposed regulations conflict with the law for requirements for underwriting pursuant to *Nieto*.	
The *Nieto* court held that Section 10384 does not impose underwriting requirements on health insurers that go beyond the long-established law of insurance; namely, that where an applicant represents to the insurer that she has no health issues, and nothing about the application or the insurer's knowledge from any other source provides reason to doubt the accuracy of the application, the insurer is permitted to rely on the applicant's representations for purposes of "complet[ing] medical underwriting" under Section 10384.	In *Nieto v. Blue Shield of California Life and Health Insurance Company,* 181 Cal.App. 4th 60 (2010) , the Court of Appeal found that Blue Shield had not violated the postclaims underwriting statute even though the Court confirmed the trial court's finding that the rescission was proper because the insured committed fraud. This ruling confirms that a finding of prohibited postclaims underwriting could bar a rescission even when fraud by the insured is established. The *Nieto* court harmonized insurance laws prohibiting fraud in the inducement and law prohibiting postclaims underwriting thus demonstrating that postclaims underwriting standards apply even in fraud cases. This case also shows that these regulations which implement, make specific and clarify postclaims underwriting standards are not inconsistent with other bases for rescission, such as fraud.
The *Nieto* court confirmed that this is the law under Section 10384. The court noted that an insurer	This comment is identical to that submitted by ACHLIC. Please see response to above comment. In fact, the *Nieto* court applied the postclaims underwriting statute even though it affirmed the trial court's finding of fraud, thus ruling that, *even in the presence of fraud*, the postclaims underwriting statute applied and, if found, could bar a rescission. Although the *Nieto* court declined to adopt the *Hailey* underwriting duty to check the accuracy and completeness of the application, the Commissioner has the

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may "rely upon him who would be insured for such information as it desires" for purposes of its underwriting. *Nieto*, 181 Cal. App.4th at 76. It also expressly declined to adopt the underwriting standard created under Health & Safety Code Section 1389.3 in *Hailey v. California Physicians' Service*, 158 Cal. App. 4th 452 (2007) — which requires a health plan to check the accuracy and completeness of applications — distinguishing the statutes that apply to health insurers from those applicable to health plans. As such, the law in California is that health insurers are not required to check the accuracy of applicant statements when underwriting applications in order to comply with Section 10384, provided that the insurer is not on notice of any reason to doubt the accuracy of those representations.	authority to require this step as part of the statutory mandate "to complete medical underwriting" required by CIC 10384.
The proposed regulations, as currently drafted, flatly conflict with the *Nieto* court's holdings. Specifically:	Disagree with the commenter's restatement of California law that health insurers are not required to check the accuracy of applicant statements when underwriting applications This is precisely the type of detail that regulations are intended to offer in implementing, making specific and clarifying a rather broad statute such as CIC 10384.
Section 2274.70(e): This proposed regulation purports to "[s]et forth requirements for the pre-issuance medical underwriting process pursuant to Insurance Code Section 10384[.]" However, the requirements set forth in the body of the proposed regulations exceed the Department's authority and are inconsistent in that they go far beyond what the *Nieto* decision held was required in order for an insurer to "complete medical underwriting" so as to preserve its later right to rescind.	Disagree. Please see Updated to Information in the Initial Statement of Reasons. This comment is an exact duplicate of that provided by ACHLIC. See response to ACHLIC comment identical to this one. The Nieto court applied the statutory requirements to Blue Shield's pre-issuance underwriting therefore ruling that even when a finding of fraud had been made, the statutory requirement to complete medical underwriting prior to issuing the policy applied.
Section 2274.74 (c) categorically prohibits any rescission when an insurer has not fully complied with the underwriting requirements laid out in subsections (a) and (b). This conflicts with the law, including the recent *Nieto* decision, in several critical respects. First, subsection (a) does not permit an insurer to rely on representations made by applicants.	**Section 2274.74 (c)** Disagree. In fact, the Nieto court applied the postclaims underwriting statute even though it affirmed the trial court's finding of fraud, thus ruling that, even in the presence of fraud, the postclaims underwriting statute continues to apply. The amended text in section 2274.74(a) clarifies that the insurer shall determine the

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Rather, it improperly imports the *Hailey* standard into the requirement to complete underwriting set forth in Section 10384. For example, the proposed regulations require insurers to obtain health history information from a source other than the applicant, and require them to consult commercially available claims or pharmaceutical databases, to verify that the information submitted by the applicant is accurate and complete.	extent to which it must engage in the underwriting activities described in the standards and that is only to the degree necessary to assure that it has obtained sufficient information to apply its medical underwriting guidelines.
Second, Section 2274.74's prohibition on rescission when an insurer has not completed underwriting as provided in these proposed regulations is inconsistent with the text of Section 10384 and the *Nieto* decision — both of which make clear that Section 10384 will only bar rescission when there has been an underwriting failure if the rescission was "due to" the underwriting failure. *See Nieto*, 181 Cal. App. 4th at 86. In other words, rescission is only prohibited when there is a linkage between the underwriting deficiency and the non-disclosed facts that led to the rescission. This is not only the law, it also makes sense. If fully complete underwriting would not have led to the discovery of the misrepresented information, there is no reason to prohibit the rescission as a result of that underwriting error. The proposed regulations eliminate the statutory requirement of linkage altogether and therefore exceed the Department's authority for such requirement.	The commenter applies an overbroad and highly selective reading of *Nieto*. On appeal, the *Nieto* court was evaluating whether or not there was a triable issue of fact concerning postclaims underwriting. The Court's finding that appellant failed to raise a triable issue of fact regarding whether or not Blue Shield completed its medical underwriting does not narrow the applicable statutory standard that an insurer must complete medical underwriting prior to issuing a health insurance policy. There is no requirement of linkage in the statute as suggested by the commenter and the Department has not exceeded its authority.
Third, Section 2274.74 contains no exception to its requirements in situations where the applicant has willfully or intentionally made material is representations or omissions. *Nieto* confirms that a willful misrepresentation entitles the insurer to rescind without regard to whether medical underwriting was completed. The Department itself properly recognized in its "Notice of Proposed Action," that accompanied the original proposed regulations, that if an insurer did not complete its underwriting, the proposed regulations will prohibit a subsequent rescission "unless it is shown that the applicant committed fraud when completing the application." Notice of Proposed Action, at Page 5. Again, this is not only the law, but also is good public policy. The fact that an insurer makes an underwriting error should not permit an insured who set out to deliberately defraud the company from reaping the fruits of that fraudulent act.	Disagree. The applicable burden of proof on the insurer with respect to the intent of the applicant is now governed by federal law which will override *Nieto*. Effective September 23, 2010,Section 2712 of the PPACA requires California insurers to prove that an applicant either committed fraud or intentionally misrepresented a material fact in the application. See extensive discussion of the impact of federal law in the Updated Informative Digest. Federal law will supersede any conflicting state case law effective September 23, 2010 with respect to the insurer's burden of proof required the applicant's state of mind in providing self-reported health history information.
Finally, Section 2274.74 is ambiguous as drafted and therefore lacks clarity. It is unclear whether insurers are required to consult all the sources set forth in subdivisions (1) through (7) or not.	Disagree. Additional sources of health history information beyond the self-reported information and at least one source of objective information are to be determined by

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Subsection (a) does not require use of any more than one additional source. At the same time, it states insurers must engage in the activities specified in subsections (1) through (7) "to the degree necessary" to complete underwriting.	the unique facts presented by each application in tandem with the insurer's medical underwriting guidelines and relies on insurer's to select underwriting activities in each case "to the degree necessary" to meet the standard enunciated in Section 2274.74 (c). " To the degree necessary" is part of the applicable standard as it must be since each insurer is entitled to use its own proprietary medical underwriting guidelines. These guidelines will dictate how much additional underwriting is required.
Section 2274.73(c): This proposed regulation limits "medical information" in a way that conflicts with the meaning of "material" in Insurance Code Section 334 and as developed in the case law. In particular, the *Nieto* court reiterated that the insurer is entitled to all "material" information, with "materiality" determined "'by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries.'" *Nieto*, 181 Cal. App. 4th at 77 (quoting Ins. Code § 33 proposed regulation appears to limit the insurer's right to only such medical information that is "essential" to calculation of risk – a far narrower standard. The insurer should have the right to request the medical information that it reasonably believes it needs, in accord with the standard that the fact that an insurer asks for certain information alone renders that information material.	**Section 2274.73 (c)** is limited to questions about health history or health conditions of the applicant. The regulation makes specific and clarifies the statute allowing "reasonable and necessary" information for medical underwriting by defining it as information essential to the insurer's calculation of prospective risk of the coverage requested. Indeed, medical underwriting is the process of quantifying and determining risks by examining medical and other information such as age. The statute itself limits the insurer to gathering information necessary to determine the risk of granting coverage. There is no meaningful difference between health history information that is necessary vs. information that is essential to determining the prospective risk. The regulation does not restrict the insurer's right to access medical information otherwise allowed by the statute.
The requirement regarding attachment or endorsement of the application on the policy is not consistent with law. The proposed regulations also contain requirements regarding attaching/endorsing the application to the policy, and consequences for failure to do so, that are inconsistent with the statutory scheme as recently interpreted in the *Nieto* decision. Section 10113 simply limits an insurer's ability to incorporate by reference into a policy external documents that the insured may never have seen, to alter the policy's stated terms. The *Nieto* court pointed out that Section 10113 is inapplicable where an insurer does not seek to alter the terms of a policy based on statements in an application or other document, but rather seeks to rescind a policy based on those pre-contract inducements. Citing a prior decision of the California Supreme Court, *Metzinger v. Manhattan Life Ins. Co.*, 71 Cal. 2d 423 (1969), *Nieto* observed that an insurer may rescind a policy where it relied in contracting on misrepresentations by the applicant. (181 Cal. App. 4th at 80).	Disagree. The proposed regulations requiring that the application be either attached to or endorsed on the policy at the time of issuance using a variety of delivery mechanisms is fully consistent with *Nieto*. Please see extended discussion of Nieto in the Update of Information in the Initial Statement of Reasons

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Section 2274.77 explicitly states that insurers must include a complete copy of the application along with the policy in order to comply with the requirements of Section 10381.5, which require an application to be either attached to or endorsed on the policy. This proposed regulation conflicts with the interpretation of the "endorse" requirement under the binding law established by *Nieto*. Interpreting Section 10381.5, the *Nieto* court stated: A reasonable and commonsense reading of the statute as a whole leads to the conclusion that it expressly contemplates the insured will not necessarily have possession of the application. (E.g., *Doe v. Roman Catholic Bishop of San Diego (2009) 178 Cal.App.4th 1382, 1388 [101 Cal. Rptr. 3d 398]* [words of a statute "must be construed in order to achieve a reasonable and commonsense interpretation when viewed in context and in light of the statute's obvious nature and purpose"].) As such, we cannot construe the statute's requirement that the application be "attached to or endorsed on" the policy to require physical attachment in all instances. (*§ 10381.5*.) Both the application and the policy here expressly and repeatedly state that the information provided in the application forms the basis for the policy's coverage. Construing *section 10381.5* to require that, in addition to these provisions, the application be physically render the "endorsed on" language meaningless. (E.g., *Manufacturers Life Ins. Co. v. Superior Court (1995) 10 Cal.4th 257, 274 [41 Cal. Rptr. 2d 220, 895 P.2d 56]* [statutory interpretations that render terms meaningless or inoperative are to be avoided].) Moreover, our construction comports with the additional general principle that the Legislature's use of the disjunctive "or" "indicates an intent to designate alternative ways of satisfying the statutory requirements. [Citations.]" (*People v. Loeun (1997) 17 Cal.4th 1, 9-10 [69 Cal. Rptr. 2d 776, 947 P.2d 1313]*; accord, *Houge v. Ford (1955) 44 Cal.2d 706, 712 [285 P.2d 257]* ["In its ordinary sense, the function of the word 'or' is to mark an alternative such as 'either this or that ... .' "].) *Nieto*, 181 Cal. App.4th at 81-82 (emphases added). Thus, the binding decisional law in California is that an insurer complies with Section 10381.5 by properly warning applicants in the application and the policy that the information submitted in the application will form the basis for the policy's coverage. The proposed regulations conflict with the decisional law. As the proposed regulations conflict with Sections 10384, 10113 and 10381.5, as construed by	**Section 2274.77** This section limits the requirement to return the application only if the insurer issues the insurance policy. This is precisely because the application becomes part of the insurance contract at the point of issuance and delivery. This is the purpose of the referenced statutes-CIC 10113 and 10381.5. Once the insurer decides to issue the policy, the application becomes part of the insurance contract which is why the statutes require attachment or endorsement on the policy. Disagree. The Nieto court found that physical attachment was not required under the unique facts of that case. Nieto also imported the phrase in CIC 10113 " in the absence of fraud" into CIC 10381.5 relying on legislative history of the two statutes. Since the trial court found fraud by Nieto, the attachment or endorsed on requirement simply did not apply in Nieto. This case does not mean that in all cases insurers can rely solely on a statement in the application that answers will form part of the basis for coverage. If CIC 10381.5 was that narrow in all circumstances, it would have been written quite differently. *Nieto* is one appellate court case where the court was presented with a unique set of facts. The Court's harmonizing of applicable statutes in that set of facts does not render the proposed regulations invalid. The proposed regulations meet the Government Code standard cited by the commenter.

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Nieto, the proposed regulations are invalid. *See, e.g.*, Gov't Code § 11342.2 ("no regulation adopted is valid or effective unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpose of the statute"); *People v. Honig*, 48 Cal. App. 4th 289, 328 (1996) (a judicial construction of a statute "become[s] as much a part of the statute as if it had [been] written by the Legislature"); *Sara M. v. Superior Court*, 36 Cal. 4th 998, 1011 (2005) (the interpretation of a statute ultimately is for the courts, not the administrative agency). For the reasons discussed above, and in the July 20, 2009 letters from Blue Shield Life and from ACLHIC, Blue Shield Life respectfully requests that the Commissioner withdraw or revise the proposed regulations.	The Department has carefully reviewed the reasons provided by the commenter and ACLHIC and declines to withdraw or further revise the proposed regulations.
California Medical Association(CMA) Armand Feliciano 05/03/10 We are particularly concerned that the proposed regulation is silent on the appropriate mental state standard in cases of rescission. In our view, the proposed regulation should codify the mental state standard required under the newly enacted federal Patient Protection and Affordable Care Act of 2010, 111 Publ. L. No. 148, 124 Stat. 119 (2010) (hereafter the "Act") to ensure clarity and consistency. By remaining silent, we believe the proposed regulation creates unnecessary ambiguity for patients, physicians, insurers, and the public in general. One rationale for the proposed regulation is to clarify the appropriate mental state standard for rescission, yet the new version of the regulation is silent on this issue. This is puzzling and unacceptable in light of the specificity provided in the Act. As you know and as reflected in the language of the proposed regulation, the Act's provisions prohibiting rescission will preempt state law to the extent the state law lends lesser protection against wrongful rescissions. We believe the proposed regulations do just that and raise a likelihood of preemption challenges in the courts.	**CMA** The Government Code does not allow the Department to interpret or implement federal law through regulations. The Department is not allowed to "codify" federal law. The PPACA has established the insurer's burden of proof with respect to the intent of the applicant in a rescission action. As discussed in the Updated Informative Digest, effective September 23, 2010, federal law requires an insurer to prove either fraud or intentional misrepresentation of a material fact before it can execute a legal rescission. The Department has determined that the federal "intent" standard does not conflict with any part of the amended text and complements the state's requirement to complete medical underwriting prior to issuing a health insurance policy.
Under the Act, group or individual health insurance policies cannot be rescinded, unless the patient or individual "has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage." Arguably, in the proposed regulation one can infer that the federal law mental state standard will govern in rescission cases. However, we believe it would provide clarity and prevent misinterpretation if DOI explicitly codified the federal mental state standard available now. Thus, we recommend the following italicized and underlined amendments:	Agree that this states the federal "intent" standard that will apply to California insurers as of September 23, 2010.

SUMMARY AND RESPONSE TO PUBLIC COMMENTS
California Department of Insurance
CCR Title 10, Chapter 5, Subchapter 2
Article 11

Verbatim Text of Comments	Response
Section 2274.78 (c) If an insurer receives medical or health history information about an insured after having issued health insurance coverage to the uninsured and such information reasonably raises a question of whether the insured misrepresented or omitted material information prior to issuance of the policy, any review or investigation conducted by the insurer shall commence immediately but in no event later fifteen (15) calendar days from receipt of the information. *As used herein, an applicant's misrepresentation or omission of material health information on the application for health insurance must constitute fraud or intentional misrepresentation of material fact as required by the Act.*	See above comment re: applicability of federal " intent" standard as of September 23, 2010.
For years, there has been ambiguity on the appropriate mental state standard in rescission cases. CMA has been at the forefront of this debate by attempting to move legislation to clarify that insurers should have the burden in satisfying an intentional misrepresentation standard in rescission cases. If patients are to be saddled with huge medical debts when they are most vulnerable (sick or hospitalized), then it is only fair to have insurers meet the higher burden of an intentional standard. We, therefore, urge DOI to pursue the appropriate course of action by adopting the federal mental state standard in the proposed regulation to end any unnecessary ambiguity for patients.	Agree that there has been some ambiguity that has been clarified by the PPACA Section 2712.
In our previous comments, we raised a number of issues to further strengthen patient protections in rescission cases, but unfortunately none were adopted. In particular, we continue to have concerns that there are insufficient patient protections under the notice requirements in Section 2274.8 (e) during a rescission investigation. In our view, patients should know that during a rescission investigation insurers are not permitted to simply compare the doctor's notes with the information available on the patient's application, that patients have the right to retain legal counsel during rescission investigations, and that insurers are required to provide all medically necessary health care services until the policy is rescinded. To the extent that insurers are required to revise patient application questionnaires in Section 2274.73 (d), they should also be mandated to submit modified applications to DOI for approval to ensure compliance. We also believe it is important to specify that insurers shall incur all costs associated with verification of patient information during the medical underwriting process in Section 2274.74 (d) to ensure that these costs are not unduly passed on to patients and physicians.	Disagree. The requirements that insurers provide notice to insureds who are subjected to a rescission investigation within specified timeframes strikes a reasonable balance between the insurer's need to make sure that an investigation is necessary and an insured's right to know once an insurer has decided to proceed. There is no legal authority for the proposition that insurer's cannot compare a doctor's notes with information on a patient's application. This comparison is allowable even if not conclusive depending on the unique facts of each rescission case. This is a decision for a court to make in a specific case. Agree. Current insurance law already requires all policy forms and health history questionnaires to be submitted to and approved by the Department.

Verbatim Text of Comments	Response
	The Department lacks the statutory authority to require insurers to assume all costs of medical underwriting though the statutory authority and responsibility to complete medical underwriting is clearly imposed on insurers alone. If providers agree via contract to provide medical records or other documents used by insurers for medical underwriting at no cost to the insurer, this type of private contractual agreement is beyond the scope of these proposed regulations. In addition, the Department lacks statutory authority to take this action.
On a related subject, we continue to urge DOI to support legislation that would establish statutory authority for DOI to create an independent review process moving forward.	The commenter's suggestion that CDI support certain types of legislation does not address the proposed text.
Kaiser Permanente Ins. Co. (KPIC) Conrad D. Llaguno 05/04/10	**KPIC**
As a general comment, we recommend that the Department of Insurance (CDI) and the Department of Managed Health Care (DMHC) coordinate in the passage of similar rescission regulations, otherwise, this will have an anomalous impact for HMOS (such as KPIC's affiliated HMO Kaiser Foundation Health Plan (KFHP)) and insurance companies which collaborate to offer jointly underwritten products. Having two substantially different regulations will result in an administrative nightmare for jointly underwritten products.	NO RESPONSE NEEDED. This general comment does not address the amended text. The Department of Insurance works collaboratively with the DMHC when possible; however each Department has obligations under its respective statutes which it must meet. DMHC has abandoned its rulemaking effort regarding rescissions.
Comment 1 **Section 2274.73(d)(4) and (d)(5)** ***(d) Questions on an application for health insurance coverage shall:*** ***(4) Provide each applicant with the opportunity to indicate whether he or she is unsure of the answer, does not know how to respond to any individual health history question, or does not understand the question. Health history questions shall ~~that~~ offer response choices in addition to YES or NO., such as Not Sure~~, on a health history questionnaire may, as appropriate, satisfy this requirement~~.*** ***(5) Offer the applicant an opportunity to indicate the applicant's inability to recall or remember the information requested. To the extent that such response choices impede the insurer's ability to apply its medical underwriting guidelines, the insurer shall pursue alternative methods of***	**Section 2274.73(d)(4) and (d)(5)** DISAGREE. The purpose of requiring the response choice of "Not Sure" in addition to Yes or No is precisely to permit the applicant a full opportunity to answer accurately and truthfully. The Department agrees that applicants have an obligation to complete their insurance application to the best of their ability and to give complete responses. By requiring the "Not Sure" response option, the applicant will better be able to meet this obligation and the insurer will gain additional insight into the health history areas where further underwriting might be warranted. The Department has had recent experience with the "Not Sure" response option and learned that insurers can in fact use this option to more efficiently underwrite an application.

Verbatim Text of Comments	Response
obtaining such information, including but not limited to telephone interviews, medical records or other sources of information. The above proposed addition of "*Not Sure*" as a response indicating the applicant does not know, doesn't know how to respond, or does not understand, can provide for responses that are ambiguous and not understandable. It also can encourage applicants to submit an incomplete application. If an individual does not understand a question, he or she may call the health insurer, broker, or their physician for guidance. If they understand the question, but do not know the answer, they should make an effort to learn the answer prior to submission. Additionally, because an insurer may not rely on an ambiguous answer, such as "Not Sure", the proposed format will result in an applicant having to experience significant delays in medical underwriting review and enrollment and/or an affected insurer issuing more denials. Thus, adoption of this regulation would adversely impact the individuals whom this regulation is intended to benefit.	The statute requires questions to be clear and unambiguous. Response options are part of the question. In order to make the question clear and unambiguous, a "Not Sure" response option must be provided. If the applicant truly cannot answer Yes or No and the truthful answer is "Not Sure", the applicant is unable to accurately respond unless the "Not Sure" response option is available. The Department disagrees that applicants will be disadvantaged by having the very clear "Not Sure" response option available.
Applicants must be subject to some obligation to make reasonable efforts to determine and gather the information requested in order to submit as complete an application as they are reasonably able. In no event should an applicant sign and submit (or permit submission of) an application he or she does not understand or is unable to complete. The standard should be for the insurer to verify the completeness and accuracy of the information submitted on the application and, if in reviewing the application, it is clear to the insurer that the applicant's responses are incomplete, to immediately follow-up with the applicant to complete the application. However, the application form itself should support that obligation, not undermine it. We believe that adoption of subparts (4) and (5) above would undermine the application review and enrollment process as it would permit and perhaps encourage applicants to submit incomplete applications.	Agree that applicants have an obligation to complete the application to the best of their layperson ability. However, this obligation does not preclude the very real possibility that an applicant may not be sure of the answer to any given health history question. Agree that it is the insurer's responsibility to verify the accuracy and completeness of the application to the degree necessary to apply their medical underwriting guidelines. An application where the applicant indicates a Not Sure response is not incomplete. Disagree that having a " Not Sure" response option will undermine the insurer's underwriting process. In fact, it should expedite it by alerting the insurer earlier to areas that require follow up.
Recommendation - Section 2274.73(d)(4) and (d)(5) **(d) Questions on an application for health insurance coverage shall:** ~~**(4) Provide each applicant with the opportunity to indicate whether he or she is unsure of the answer, does not know how to respond to any individual health history question, or does not understand the question. Health history questions that offer response choices in addition to YES or NO, such as Not Sure, on a health history questionnaire may, as appropriate,**~~	

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~~satisfy this requirement.~~ **(~~5~~4) Offer the applicant an opportunity to describe health related issues where they applicant may have questions about the importance or significance of the information requested. ~~to indicate the applicant's inability to recall or remember the information requested.~~ To the extent that such response choices impedes the insurer's ability to complete medical underwriting ~~apply its medical underwriting guidelines~~, the insurer shall pursue alternative methods of obtaining such information, including but not limited to telephone interviews, obtaining applicant's medical records or other sources of information that may be readily accessible and relevant to the insurer's underwriting decision.**	
Comment 2 **Section 2274.78(c)** ***(c) If an insurer receives medical or health history information about an insured after having issued health insurance coverage to the insured and such information reasonably raises a question of whether the insured misrepresented or omitted material information prior to issuance of the policy, any review or investigation conducted by the insurer shall commence immediately but in no event later than fifteen (15) calendar days from receipt of the information. The dates relevant to the conduct of the investigation and any decisions regarding the investigation shall be clearly documented in the insurer's claim file. ~~As used herein, an applicant's misrepresentation or omission of material health information on the application for health insurance must be of facts known to the applicant and the insurer must ascertain that the applicant appreciated the significance of the information requested.~~*** Fifteen calendar days is insufficient for insurers and HMOs to determine if there is truly a rescission- investigation trigger identified. Particularly for KFHP, with its integrated model of health care delivery, such issues are not usually identified through the claims process. KFHP requests a 60-day window for initial review of such information.	**Comment 2** **Section 2274.78 (c)** DISAGREE. The Department of Insurance regulates insurers, not HMO plans. The 15 day requirement is not the time limit for reviewing the information as stated in the comment; it is the timeframe within which the insurer must commence the review. The requirement in this Section is that an insurer commences a review or investigation of a possible rescission within 15 days of receiving medical or health history information. It arises if the insurer has either received a claim or a notice of a claim as defined in 2274.78(a).
In addition, we appreciate the CDI moving away from the term “willful misrepresentation” and the	CDI has never used the term “willful misrepresentation” as it is not included in the CIC Section 10384. The text of the regulation has been amended to delete the

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requirement to "ascertain" that an applicant appreciated the significance of the information requested. However, the Department's Initial Statement of Reasons mentions the "Reasonable Layperson Standard", yet it is not clearly referenced in the proposed text of the regulation. Using language similar to the prudent layperson definition of an emergency under the Knox Keene laws will lead to less confusion when trying to resolve rescission issues.

Recommendation - Section 2274.78(c)
(c) If after issuing health insurance coverage to an insured an insurer receives medical or health history information about ~~an insured~~ the insured that ~~after having issued health insurance coverage to the insured and such information~~ reasonably ~~raises a question of whether~~ indicates that the insured misrepresented or omitted material health history information on his or her application prior to issuance of the policy, any ~~review or~~ investigation undertaken by the insurer to ascertain whether in fact such misrepresentation or omission occurred ~~conducted by the insurer~~ shall commence ~~immediately~~ as soon as practicable, but in no event later than ~~fifteen (15)~~ sixty (60) calendar days from the insurer's receipt of ~~the~~ such information. ~~The dates relevant to the conduct of the investigation and any decisions regarding the investigation shall be clearly documented in the insurer's claim file.~~ The insurer shall document its investigation and decisions regarding its investigation to demonstrate compliance with this section.

[Clean version below]
(c) If after issuing health insurance coverage to an insured an insurer receives medical or health history information about the insured that reasonably indicates that the insured misrepresented or omitted material health history information on his or her application prior to issuance of the policy, any investigation undertaken by the insurer to ascertain whether in fact such misrepresentation or omission occurred shall commence as soon as practicable, but in no event later than sixty (60) calendar days from the insurer's receipt of such information. The insurer shall document its investigation and decisions regarding its investigation to demonstrate compliance with this section.

Comment 3
2274.78(d) and (e)

Response

requirement that the insurer ascertain that the applicant appreciated the significance of the information requested because this requirement has been supplanted by new federal law enacted on March 23, 2010, the Patient Protection and Affordable Care Act of 2010. Section 2712 of that Act established the requirement that the insurer may only rescind health insurance upon proof of intentional misrepresentation of a material fact or fraud.

The "Reasonable Layperson Standard" is defined in Section 2274.72(b). This definition is consistent with the prudent layperson standard found in federal law and other State laws such as the Health and Safety Code governing health service plans licensed under the Knox Keene law..

Comment 3
2274.78(d) and (e)

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(d) Immediately but in no event later than seven (7) days after an insurer's decision to commence an investigation or review as described in subdivision (c), the insurer shall send a written notice to the insured that it is conducting an investigation as described in subdivision (c). ***(e) In the required written notice to the insured described in subdivision (d), the insurer shall clearly describe, in lay terms, the reason for the investigation and the substantive information on which the investigation is based. The insurer shall include with the notice copies of any applicable documents, such as claims, medical records, or any other information in the insurer's possession at the time of the notice and that is included in the insurer's review and investigation. The insurer shall provide to the insured all documents the insurer uses in its investigation that provided the basis for initiating the investigation except that an insurer is not required to provide documents that are otherwise protected by law.*** A true investigation could include obtaining outside medical records, retrieval of other off-site documents, and multiple other time consuming steps. To gather and evaluate this information in seven days, and provide a complete set to the insured would risk notices to people who really are not subject to rescission, or a lost opportunity to use information gathered after the seven days have passed. The proposed language would result in enrollees being unnecessarily alarmed that their coverage was at risk.	DISAGREE. This Section does not require that the insurer complete gathering and evaluating the referenced information within 7 days. This Section requires that the insured receive notice of the insurer's decision to commence a rescission investigation within 7 days of its actual commencement. This Section requires the insurer to provide only whatever information it possesses at the time of the notice. Any information that an insurer has not yet obtained, such as medical records, is not required to be sent with the 7 day notice of commencement of the investigation.
Due to California's regulatory scheme, it is preferable to have one set of timelines for this process for all regulators. We ask that the Department collaborate with the DMHC on the timeframes and requirements for rescission review and investigation.	AGREE. The Department of Insurance works collaboratively with the DMHC when possible; however each Department has obligations under its respective statutes which it must meet. DMHC has abandoned its rulemaking effort regarding rescissions.
Additionally, in instances of fraud investigation by the Department's Fraud Division or other government agencies, relative to imposing criminal or civil sanctions, the notice requirement of 2274.78(d) may conflict with instructions the insurer receives pursuant to the investigation. (CIC §1872.4(a) and §1877.3(d), CCR Title 10, §2698.34 *et seq*.)	In the unlikely event that an insurer's adherence to the notice to insured requirements in the proposed regulations conflicted with a Department or other government agency's fraud investigation, the involved law enforcement officials will have to reconcile any potential conflict as part of the investigative process. This is highly unlikely as there have been no criminal sanctions imposed on insureds who were ultimately rescinded for fraud in the inducement of a contract with an insurer.
Recommendation - 2274.78(d) and (e) **(d) Immediately but in no event later than ~~seven (7)~~ thirty (30) days after an insurer's decision to commence an investigation or review as described in subdivision (c), the insurer shall send a written notice to the insured that it is conducting an investigation as described in subdivision (c). This notice requirement shall not preempt the authority of the Department's**	

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Fraud Division, or other law enforcement or licensing agencies to investigate and prosecute suspected violations of law. **(e) In the required written notice to the insured described in subdivision (d), the insurer shall clearly describe, in lay terms, the reason for the investigation and the substantive information on which the investigation is based. The insurer shall include with the notice copies of any applicable documents, such as claims, medical records, or any other information in the insurer's possession at the time of the notice and that is included in investigation. The insurer shall provide to the insured all documents the insurer uses in its investigation that provided the basis for initiating the investigation except that an insurer is not required to provide documents that are otherwise protected by law.**	
Comment 4 *2274.77* ***(a) At the time of issuance and delivery of the policy, the insurer shall return to the insured a complete copy of the application for health insurance coverage attached to the health insurance policy with an express instruction to the applicant to review the copy of the application.*** Given the adoption of web-based application submission, KPIC asks for clarification that electronic forms of documents will meet the regulatory requirements set forth in this section. Inasmuch as amended §2274.71 (b) does not preclude the insurer's use of new underwriting methods or techniques, we believe that in acknowledgement of the prevalence of use of electronic delivery of documents, the regulations should expressly allow such electronic issuance and delivery of the policy and completed application. **Recommendation** **(a) At the time of issuance and delivery of the policy, the insurer shall return to the insured a complete copy of the application for health insurance coverage attached to the health insurance policy with an express instruction to the applicant to review the copy of the application. Use of electronic forms of documents satisfies the requirements of this section.**	**Comment 4** *2274.77* DISAGREE. Electronic communications are governed by Civil Code Section 1633.2(g) and are therefore subject to these regulations to the extent such electronic communications are in lieu of any non-electronic communications or documents used by the insurer.
Comment 5 *2274.72* ***(d) "Personal Health Record" ("PHR") means a dynamic set of personal health history***	**Comment 5** *2274.72*

Verbatim Text of Comments	Response
information derived from a private, secure database maintained by a health insurer or health plan and that contains medical claims and other information. A PHR may be "autopopulated" with medical and related information, including claims records reflecting diagnoses and procedure codes, dates of treatments, prescription records, medical testing and other allowed clinical information. A PHR is distinct from an electronic medical record, which is primarily intended for use by medical professionals. A PHR is designed primarily for use by the insured. As used in this article, a PHR refers exclusively to a record of health history information maintained by an insurer or health plan for use by its covered persons. An insurer may ignore any applicant-generated health information purporting to be part of a PHR. KPIC requests clarification of the meaning of the sentences added to §2274.72(d) in the amended regulation. Specifically, what type of information would be "applicant-generated health information" within a PHR?	As one example, applicant-generated health information may include but is not limited to: letters, emails, notes, and/or health records from the insured or his/her health care provider. The point of the amendment is to relieve insurers of any possible obligation to use applicant-generated information if present.

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